Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements		
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DRAFT

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-35	35.001	The system shall be able to audit the date/time and user of each instance when a client chart is printed by the system.	Does not include screen print and other functions that are external to the programmed functionality of the EHR system.	1		M	M	H	
F-35	35.002	The system shall provide a means to document a client's dispute with information currently in their chart.	This does not imply that the client can document directly in their chart. Some methods include but are not limited to allowing the client a view only access to their record, printing a copy of the record for a client to review. Methods to include the information in the chart could be as a note, a scanned copy of client comments, an addendum to the note or other method not described.	1		L	L	M	H
F-35	35.003	The system shall be able to identify all users who have accessed an individual's chart over a given time period, including date and time of access.	Specific items/sections of information accessed shall be identified, with appropriate audit trail.	1		M	M	H	
F-35	35.004	The system shall be able to identify certain information as confidential and only make that accessible by appropriately authorized users.	This may be implemented by having a "confidential" section of the chart	1		M	M	H	
F-35	35.005	The system shall be able to prevent specified user(s) from accessing a designated client's chart	An example would be preventing access to a VIP or staff member's chart. When access is restricted, the system shall provide a means for appropriately authorized users to "break the glass" for emergency situations. Such overrides shall be audited.	1		M	L	M	H

F-36	36.001	The system shall be able to retain data until otherwise purged, deleted, archived or otherwise deliberately removed.		1		H			
F-36	36.002	The system shall provide a method for archiving health record information.	Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.	1		L	M	H	
F-36	36.003	The system shall be able to retrieve information that has been archived.	Retrieval does not imply restoration to current version of the software.	1					
F-36	36.004	The system shall be able to store and retrieve health record data and clinical documents for the legally prescribed timeframes.		1					
F-36	36.005	The system shall be able to retain inbound data or documents (related to health records), as originally received (unaltered, inclusive of the method in which they were received), for the legally prescribed time frames, in accordance with users' scope of practice, organizational policy or jurisdictional law.		1					
F-36	36.006	The system shall be able to retrieve information in a manner conducive to recreating the context in which the information was obtained.		1					
F-36	36.007	The system shall be able to retrieve all the elements included in the definition of a legal health (medical) record.		1					
F-36	36.008	The system shall provide for oversight, review and confirmation of record(s) destruction prior to destroying specific EHR data/records.		1					
F-36	36.009	The system shall be able to destroy EHR data/records so that all traces are unrecoverable, according to policy and legal retention periods.		1					
F-37	37.001	The system shall be able to log outgoing information exchange in an auditable form.	In future, the work group will clarify details of what shall be included in the log, and revise timing of this criterion based on those elements, if required.	1		L	L	H	
F-37	37.002	The system shall be able to log the receipt of documents in an auditable form.		1		L	L	M	H
F-37	37.003	The system shall track and can produce a report of every transaction initiated on the system, identifying the user, location, date, time, function, file accessed, record accessed. There will be sufficient capacity to archive this information for 7 years. Transactions include read, write, execute, and delete. The system will support internal audit and review by the local Privacy Officer.		1					

F-37	**37.004**	The system shall allow administrators control over which system components will have audit controls in place and what types of audit trails are utilized.	Examples are: tracking record additions, edits, and deletions, but not record lookups.	**1**					
F-38	**38.001**	The system shall be able to export (extract) pre-defined set(s) of data out of the system	For example, export of performance measures, ability to query data base, chronic disease management tools.	**1**		H			
F-38	**38.002**	The system shall be able to import data into the system	Data import implies receiving discrete data into the EHR in an automated manner as opposed to manual data entry or document scanning. This could be accomplished via a real time or batch interface or a manual data load.	**1**		M	H		
F-38	**38.003**	The system shall allow removal of discrete client identifiers.	De-identification is necessary for research purposes, e.g., to identify patterns of disease. External applications can be used to meet this criteria.	**1**		L	M	H	
F-38	**38.004**	The system shall be able to specify the intended destination of the extracted information.	The user may indicate to whom they are sending results. The lack of control of information once it leaves the practice is acknowledged.	**1**		L	L	M	H
F-39	**39.001**	The system shall allow multiple users to interact concurrently with the EHR application.		**1**		H			
F-39	**39.002**	The system shall allow concurrent users to simultaneously view the same EHR administrative and / or financial record data.		**1**		H			
F-39	**39.003**	The system shall allow concurrent users to view the same EHR clinical documentation or template.		**1**		H			
F-39	**39.004**	The system shall provide protection to maintain the integrity of clinical data during concurrent access.	To prevent users from simultaneously attempting to update a record with resultant loss of data	**1**		H			
F-39	**39.005**	The system shall simultaneously trigger alerts to users of each other's presence in the same record, where such access is permitted.	Moved from Admin Workflow 43.044.	**1**					
F-43	**43.013**	The system shall support the downloading, uploading and security of data to and from mobile devices such as laptops, tablet computers, and personal digital assistants, to support mobile workers.		**1**					
F-43	**43.038**	The system shall be scalable to meet current and future user access and data storage needs.		**1**					

F-43	**43.039**	The system shall incorporate a consistent user interface (UI) for data entry. The UI design should independent of the proposed hardware configuration.		**1**					
F-43	**43.040**	The system shall support a variety of data input modalities, including: Voice recognition, Touch screen, Light pen, Mouse, Keyboard		**1**					
F-43	**43.041**	The system shall support remote system monitoring technology.		**1**					
F-43	**43.042**	The system shall incorporate extensive, secure capabilities that link staff and clinicians from remote locations to the central site.		**1**					
F-43	**43.047**	The system shall support industry standard locking mechanisms to prevent multiple users from simultaneously accessing/updating patient data as appropriate.		**1**					
F-43	**43.048**	The system shall support and implement redundancy/fault tolerance for 100% availability.		**1**					
F-43	**43.049**	The system shall Web-based with appropriate security measures to meet HIPAA compliance requirements.		**1**					
F-43	**43.050**	The system shall efficiently manage both structured and unstructured health record information during manual and electronic, retrieval, update, reporting, and tracking processes.	Management of actions involving complete or partial records is included.	**1**					
F-43	**43.051**	The system shall support efficient linkage of all associations between structured and unstructured health record information.	Includes structured to structured, unstructured to unstructured, and structured to unstructured data associations.	**1**					
S-01	**1.001**	The system shall enforce the most restrictive set of rights/privileges or accesses needed by users/groups (e.g. System Administration, Clerical, Nurse, Doctor, etc.), or processes acting on behalf of users, for the performance of specified tasks.		**1**		X			X
S-01	**1.002**	The system shall provide the ability for authorized administrators to assign restrictions or privileges to users/groups.		**1**		X			X

S-01	**1.003**	The system must be able to associate permissions with a user using one or more of the following access controls: 1) user-based (access rights assigned to each user); 2) role-based (users are grouped and access rights assigned to these groups); or 3) context-based (role-based with additional access rights assigned or restricted based on the context of the transaction such as time-of-day, workstation-location, emergency-mode, etc.)		**1**		X			X
S-01	**1.004**	The system shall support removal of a user's privileges without deleting the user from the system. The purpose of the criteria is to provide the ability to remove a user's privileges, but maintain a history of the user in the system.		**1**			X		
S-01	**1.013**	The system shall provide the ability to create sets of access control permissions granted to users (both human and other applications).		**1**					
S-01	**1.014**	The system shall authorize users to access the applications based on the following: User identity, User role, User work assignment, User location, Client's present condition, Context.		**1**					
S-01	**1.015**	The system shall allow the system administrator to: Add authorized users, Delete (or inactivate) authorized users, Modify a user's current access profile.		**1**					
S-01	**1.016**	The system shall provide the ability to define user access rules.		**1**					
S-01	**1.017**	The system shall enforce the access rules for all EHR resources, based on the application's physical/logical configuration.		**1**					
S-01	**1.018**	The system shall provide the ability to define user access to the application's functions.		**1**					
S-01	**1.019**	The system shall require passwords be changed at a user-defined time interval.		**1**					

S-01	**1.020**	The system shall provide automatic notifications to users upon successful access to the application that the current password is due to expire.		**1**					
S-01	**1.021**	The system shall be able to set the number of days prior to the password expiration date; the system is to display the notification.		**1**					
S-01	**1.022**	The system shall prohibit access to the application by users entering expired passwords.		**1**					
S-01	**1.023**	The system shall provide the ability to automatically log users out of the application after a user-defined number of seconds/minutes of inactivity.		**1**					
S-01	**1.024**	The system shall comply with all appropriate California State and federal legislation Department of Mental Health rules regarding patient confidentiality and privacy.		**1**					
S-01	**1.025**	The system shall maintain varying levels of confidentiality in accordance with users' scope of practice, organizational policy or jurisdictional law.		**1**					
S-01	**1.026**	The system shall allow certain role clinicians to mark a cleint's specific information as blinded, prohibiting access to all other users. Note: The standards in this area are still evolving.	Was 7.001 but Category 7: Security Access Control was consolidated into Category 1: Security Access Control	**1**				X	
S-01	**1.027**	The system shall support access to blinded information to a treating clinician, when the blinded information is necessary for managing an emergency condition. Note: This is commonly known as a "break the glass" function. This does not provide increased access rights for the user.	Was 7.002 but Category 7: Security Access Control was consolidated into Category 1: Security Access Control	**1**				X	
S-01	**1.028**	The "break the glass" function must be capable of requiring the clinician requesting access to blinded information to document and record the reason(s) for requesting access.	Was 7.003 but Category 7: Security Access Control was consolidated into Category 1: Security Access Control	**1**				X	
S-02	**2.001**	The system shall authenticate the user before any access to Protected Resources (e.g. PHI) is allowed, including when not connected to a network e.g. mobile devices.		**1**		X			X

S-02	**2.002**	When passwords are used, the system shall support password strength rules that allow for minimum number of characters, and inclusion of alpha-numeric complexity.		**1**		X			X
S-02	**2.003**	The system upon detection of inactivity of an interactive session shall prevent further viewing and access to the system by that session by terminating the session, or by initiating a session lock that remains in effect until the user reestablishes access using appropriate identification and authentication procedures. The inactivity timeout shall be configurable.		**1**		X			X
S-02	**2.004**	The system shall enforce a limit of (configurable) consecutive invalid access attempts by a user. The system shall protect against further, possibly malicious, user authentication attempts using an appropriate mechanism (e.g. locks the account/node until released by an administrator, locks the account/node for a configurable time period, or delays the next login prompt according to a configurable delay algorithm).		**1**		X			X

S-02	**2.005**	When passwords are used, the system shall provide an administrative function that resets passwords.		**1**		X			X
S-02	**2.006**	When passwords are used, user accounts that have been reset by an administrator shall require the user to change the password at next successful logon.		**1**			X		
S-02	**2.007**	The system shall provide only limited feedback information to the user during the authentication.		**1**		X			X
S-02	**2.008**	The system shall support case-insensitive usernames that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).		**1**		X			X
S-02	**2.009**	When passwords are used, the system shall allow an authenticated user to change their password consistent with password strength rules (S13).		**1**		X			X
S-02	**2.010**	When passwords are used, the system shall support case-sensitive passwords that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).		**1**		X			X
S-02	**2.011**	When passwords are used, the system shall not store passwords in plain text.		**1**		X			X
S-02	**2.012**	When passwords are used, the system shall prevent the reuse of passwords previously used within a specific (configurable) timeframe (i.e., within the last X days, etc. - e.g. "last 180 days"), or shall prevent the reuse of a certain (configurable) number of the most recently used passwords (e.g. "last 5 passwords").		**1**			X		
S-02	**2.013**	The system shall authenticate all users (both human and other applications) attempting to access the application.		**1**					
S-02	**2.014**	The system shall provide any of the following types of authentication: Username/password, Digital certificate, Secure token, Biometrics		**1**					
S-02	**2.015**	The system shall provide the ability to implement Chain of Trust agreements.		**1**					
S-02	**2.016**	The system shall support two-factor authentication in alignment with NIST 800-63 Level 3 Authentication. Note: The standards in this area are still evolving.	Was 5.001 but Category 5: Security Authentication was consolidated into Category 2: Security Authentication	**1**					

S-02	**2.017**	When passwords are used, the system shall not transport passwords in plain text.	Was 4.002. Moved to Security Authentication 2.017	**1**		X			X
S-02	**2.018**	When passwords are used, the system shall not display passwords while being entered.	Was 4.003. Moved to Security Authentication 2.018	**1**		X			X
S-03	**3.001**	The system shall include documentation available to the customer that provides guidelines for configuration and use of the EHR security controls necessary to support secure and reliable operation of the system, including but not limited to: creation, modification, and deactivation of user accounts, management of roles, reset of passwords, configuration of password constraints, and audit logs.		**1**		X			X
S-04	**4.001**	The system shall support protection of confidentiality of all Protected Health Information (PHI) delivered over the Internet or other known open networks via encryption using triple-DES (3DES) or the Advanced Encryption Standard (AES) and an open protocol such as TLS, SSL, IPSec, XML encryptions, or S/MIME or their successors.		**1**		X			X
S-04	**4.004**	For systems that provide access to PHI through a web browser interface (i.e. HTML over HTTP) shall include the capability to encrypt the data communicated over the network via SSL (HTML over HTTPS). Note: Web browser interfaces are often used beyond the perimeter of the protected enterprise network		**1**		X			X
S-04	**4.005**	The system shall support protection of integrity of all Protected Health Information (PHI) delivered over the Internet or other known open networks via SHA1 hashing and an open protocol such as TLS, SSL, IPSec, XML digital signature, or S/MIME or their successors.		**1**		X			X
S-04	**4.006**	The system shall support ensuring the authenticity of remote nodes (mutual node authentication) when communicating Protected Health Information (PHI) over the Internet or other known open networks using an open protocol (e.g. TLS, SSL, IPSec, XML sig, S/MIME).		**1**		X			X

S-04	**4.007**	The system, when storing PHI on any physical media intended to be portable/removable (e.g. thumb-drives, CD-ROM, PDA), shall support use of a standards based encrypted format using triple-DES (3DES), and the Advanced Encryption Standard (AES).		**1**					
S-04	**4.008**	The system shall have security measures to project data being transmitted via wireless networks, including data communications with portable devices.		**1**					
S-04	**4.009**	The system shall provide the ability to obfuscate (intentionally make difficult to read) data.		**1**					
S-04	**4.010**	The system shall encrypt and de-encrypt data that is received and/or transmitted over a non-secure network.		**1**					
S-04	**4.011**	The system shall support standard data encryption protocols.		**1**					
S-04	**4.012**	The system shall route data only to/from known, registered, and authenticated applications using secure networks.		**1**					
S-04	**4.013**	The system shall provide the ability to store a user identifier with data other than the user who entered that data.		**1**					
S-04	**4.014**	The system shall support the storage of any Protected Health Information (PHI) data on any associated mobile device(s) such as PDAs, smartphones, etc. in an encrypted format, using triple-DES (3DES), the Advanced Encryption Standard (AES), or their successors.	Was 6.001 but Category 5: Security Technical Services was consolidated into Category 4: Security Technical Services	**1**					
S-04	**4.015**	The system, prior to a user login, shall display a (configurable) notice warning (e.g. "The system should only be accessed by authorized users").	Was 6.002 but Category 5: Security Technical Services was consolidated into Category 4: Security Technical Services	**1**					
S-04	**4.016**	The system shall be able to support time synchronization using NTP/SNTP, and use this synchronized time in all security records of time.	Moved from Security Access Control: 1.008	**1**		X			X
S-04	**4.017**	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T08:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.	Moved from Security Access Control: 1.009	**1**			X		
S-05	**5.001**	The system shall support logging to a common audit engine using the schema and transports specified in the Audit Log specification of IHE Audit Trails and Node Authentication (ATNA) Profile	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.002**	The system shall maintain an audit log of all failed access attempts.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					

S-05	**5.003**	The system shall date/time stamp: Initial data entry, Data modificaiton, Exchange of data (date/time data is formatted and transmitted from EHR-S to another application), Data deleted or inactivated, Report requested, Query requested	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.004**	The system shall store the identity of the user for every instance of: Data entry, Data modification, Exchange of data, Data deleted or inactivated, Report requested, Query performed.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.005**	The system shall support any of the following types of user identifiers when storing user identity: Password, Digital certificate, Unique entity identifier (e.g., application's IP address[1], sending facility CLIA[2] number, etc.)	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.006**	The system shall provide an audit trail of new software versions loaded, or changes to the EHR application.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.007**	The system shall provide an audit trail of new versions of standard code sets and knowledge bases.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.008**	The system shall provide and audit trail of all successful and unsuccessful backups.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.009**	The system shall provide an audit trail of all application recoveries from backup media.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.010**	The system shall provide an audit trail of any date/time changes if this is a required activity.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.011**	The system shall provide an audit trail for all archiving of data.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.012**	The system shall provide an audit trail when re-activating an archived client record.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.013**	The system shall provide an audit trail of all user/application entries and exits from the EHR application.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					

S-05	**5.014**	The system shall provide an audit trail of all remote access connections including those for system support and maintenance activities.	Category 8: Security Audit was renumbered as Category 5: Security Audit	**1**					
S-05	**5.015**	The system shall be able to detect security-relevant events that it mediates and generate audit records for them. At a minimum the events shall include: start/stop, user login/logout, session timeout, account lockout, cleint record created/viewed/updated/deleted, scheduling, query, order, node-authentication failure, signature created/validated, PHI export (e.g. print), PHI import, and security administration events. Note: The system is only responsible for auditing security events that it mediates. A mediated event is an event that the system has some active role in allowing or causing to happen or has opportunity to detect. The system is not expected to create audit logs entries for security events that it does not mediate.	Moved from Security Access Control: 1.005.	**1**				X		
S-05	**5.016**	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and cleint identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.	Moved from Security Access Control: 1.006	**1**		X				X
S-05	**5.017**	The system shall provide authorized administrators with the capability to read all audit information from the audit records in one of the following two ways: 1) The system shall provide the audit records in a manner suitable for the user to interpret the information. The system shall provide the capability to generate reports based on ranges of system date and time that audit records were collected. 2) The system shall be able to export logs into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).	Moved from Security Access Control: 1.007	**1**		X				X
S-05	**5.018**	The system shall prohibit all users read access to the audit records, except those users that have been granted explicit read-access. The system shall protect the stored audit records from unauthorized deletion. The system shall prevent modifications to the audit records.	Moved from Security Access Control: 1.010	**1**		X				X
S-05	**5.019**	The system shall allow an authorized administrator to enable or disable auditing for groups of related events to properly collect evidence of compliance with implementation-specific policies. Note: In response to a HIPAA-mandated risk analysis and management, there will be a variety of implementation-specific organizational policies and operational limits.	Moved from Security Access Control: 1.012	**1**				X		

S-06	**6.002**	The system restore functionality shall result in a fully operational and secure state. This state shall include the restoration of the application data, security credentials, and log/audit files to their previous state.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**		X			X
S-06	**6.003**	If the system claims to be available 24x7 then the system shall have ability to run a backup concurrently with the operation of the application.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**		X			X
S-06	**6.004**	The system's data and program files are capable of being backed up by common third party backup tools.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**					
S-06	**6.005**	The system shall provide for the purging and storage of data that is no longer needed on a real-time basis by county staff.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**					
S-06	**6.006**	The system shall provide for: User defined archiving of data (based on service date, date of last activity, or other user-defined characteristics); Printed reports of data being archived; ability to selectively restore archived data; proper control over archiving of data where a patient has an outstanding balance; archiving data to disk, tape or other storage media.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**					
S-06	**6.007**	The system shall support efficient recovery from an interruption in the power supply both during business hours and after hours when no staff are on-site, or in other situations where user data has been lost or otherwise compromised.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**					
S-06	**6.008**	The system architecture allows the system to recover from service interruptions with no or minimal loss of data, as well as minimal level of effort to return the system to the pre-interruption state. Methods are in place to ensure that any data initially lost during a system interruption is readily recoverable.	Category 9: Reliability Backup and Recovery was renumbered as Category 6.	**1**					
S-07	**7.001**	The system shall include documentation available to the customer stating whether or not there are known issues or conflicts with security services in at least the following serivce areas: antivirus, intrusion detection, malware eradication, host-based firewall and the resolution of that conflict (e.g. most systems should note that full virus scanning should be done outside of peak usage times and should exclude the databases.).	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			X
S-07	**7.002**	If the system includes hardware, the system shall include documentation that covers the expected physical environment necessary for proper secure and reliable operation of the system including: electrical, HVAC, sterilization, and work area.	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			X

S-07	**7.003**	The system shall include documentation that itemizes the services (e.g. PHP, web services) and network protocols/ports (e.g. HL-7, HTTP, FTP) that are necessary for proper operation and servicing of the system, including justification of the need for that service and protocol. This information may be used by the healthcare facility to properly configure their network defenses (firewalls and routers).	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		x			X
S-07	**7.004**	The system shall include documentation that describes the steps needed to confirm that the system installation was properly completed and that the system is operational.	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			x
S-07	**7.005**	The system shall include documentation that describes the patch (hot-fix) handling process the vendor will use for EHR, operating system and underlying tools (e.g. a specific web site for notification of new patches, an approved patch list, special instructions for installation, and post-installation test).	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			x
S-07	**7.006**	The system shall include documentation that explains system error or performance messages to users and administrators, with the actions required.	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			X
S-07	**7.007**	The system shall include documentation of product capacities (e.g. number of users, number of transactions per second, number of records, network load, etc.) and the baseline representative configurations assumed for these capacities (e.g. number or type of processors, server/workstation configuration and network capacity, etc).	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			X
S-07	**7.008**	The system shall include documented procedures for product installation, start-up and/or connection.	Category 10: Reliability: Documentation was renumbered as Category 7.	**1**		X			X
S-07	**7.009**	The system shall include documentation of the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and/or serviceability.	Was 12.001. Category 12: Reliability: Documentation was consolicated into Category 7.	**1**		X			X
S-08	**8.001**	The software used to install and update the system, independent of the mode or method of conveyance, shall be certified free of malevolent software (“malware”). Vendor may self-certify compliance with this standard through procedures that make use of commercial malware scanning software.	Category 11: Reliability: Technical Services was renumbered as Category 8.	**1**		X			X
S-08	**8.002**	The system shall be accessible and available for all authorized users 99.5% of the time.	Category 11: Reliability: Technical Services was renumbered as Category 8.	**1**					
S-08	**8.003**	The system shall support response times of 2 seconds or less 90% of the time.	Category 11: Reliability: Technical Services was renumbered as Category 8.	**1**					
S-08	**8.004**	The system shall support sub-second response times 80% of the time.	Category 11: Reliability: Technical Services was renumbered as Category 8.	**1**					
S-08	**8.005**	The system shall support and implement redundancy/fault tolerance for 100% availability.	Category 11: Reliability: Technical Services was renumbered as Category 8.	**1**					
S-08	**8.006**	The system shall be configurable to prevent corruption or loss of data already accepted into the system in the event of a system failure (e.g. integrating with a UPS, etc.).	Was 13.001. Category 13: Reliability: Technical Services was consolicated into Category 8.	**1**		X			X

Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements	**g**	
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DRAFT

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-01	1.001	The system shall allow creation of an EHR that is uniquely associated to a single client.		2		H			
F-01	1.002	The system shall associate (store and link) key identifier information (e.g., system ID, health record number) with each client record.	Key identifier information shall be unique to the client record but may take any system defined internal or external form.	2		H			
F-01	1.003	The system shall provide functionality to record multiple non medical record identifier for single client. (e.g. SNN, pseudo SNN, and CIN, Drivers License or St ID#)	For interoperability, practices need to be able to store additional client identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national client identifiers if/when such become available.	2		H			
F-01	1.004	The system shall provide a field to identify the identifier type.		2					
F-01	1.005	The system shall use key identifying information to identify (look up) the unique client record.		2		H			
F-01	1.006	The system shall provide more than one means of identifying (looking up) a client.	Examples of identifiers for looking up a client include date of birth, phone number.	2		H			
F-01	1.007	The system shall provide a field or fields which will identify clients as being exempt from reporting functions. Note: Work with DMH to review this item for Behavioral Health.	Examples include clients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a client who will be included in reports. De-identifying clients for reporting is addressed in the "Health record output" functionality.	2					

F-01	1.008	The system shall allow the user to choose from which reporting functions client identifiers shall be excluded.	Example: Exclude from case load reports but include in CSI reporting.	2					
F-01	1.009	The system shall be able to merge duplicate client records including claim data, demographic, financial, clinical and all service/treatment data.	If a duplicate chart is created, information could be merged into one chart.	2			H	X	
F-01	1.010	The system shall provide a mechanism for user to designate which merging data elements are to be retained as the primary record. Retain all records and mark the file as merged. Account for and store deleted MRN with cross reference.		2					
F-01	1.011	The system shall efficiently integrate with community resource databases, client wait lists, call logging, intake screening, pre-registration, registration , remote registration, and client referral systems which gather or distribute client demographic and financial information related to an existing or potential client.	Examples of caller data are date of call, staff receiving call, name, telephone number, language requirement, referring party, and call disposition.	2					
F-01	1.012	The system shall integrate with user-defined registration screens, that capture required federal, state, and local registration demographic and financial information.	Examples are: CSI, PATH, and SAMHSA , and UMDAP sliding scale data requirements.	2					
F-01	1.013	The system shall be easily configurable to support additional patient identification related to client service/treatment funding.	Examples are categorical funding and grants.	2					
F-01	1.014	The system shall cross check name inquiries to identify alias names.	Clients may have multiple alias names as well as other multiple Personal Identifiers such as Date of Births (DOB), Social Security Numbers, etc	2					
F-01	1.015	The system shall allow system administrators to link patient identifiers with client demographic data fields used for meeting local data requirements.		2					
F-01	1.016	The system shall automatically check for duplicates, i.e., entering a client with the same name and date of birth. If a suspected duplicate is found the system shall notify the user of the potential duplication and request confirmation of the entry.		2					
F-01	2.018	The system shall provide intake forms designed to display current data in the system, such as demographic items. The intake form can be designed to include various types of data including: free text, multiple choice, and drop down menu items.	Moved from 3.016	2					

F-02	**2.001**	The system shall capture and maintain demographic information as part of the client record. This information shall be able to be included in reports. Demographic data shall be able to accommodate minimum data sets as established by various regulatory bodies and reporting requirements..	Examples of a minimum set of demographic data elements include: name, address, phone number and date of birth. It is assumed that all demographic fields necessary to meet legislative and regulatory (e.g., HIPAA), research, and public health requirements will be included. A desirable feature would be a method of identifying how clients would like to be contacted (e.g., alternate addresses). De-identifying demographic information is addressed in the "Health record output" functionality.	**2**		H			
F-02	**2.002**	The system shall be able to maintain and make available historic information record using effective and end dates for demographic data including prior names, addresses, phone numbers and email addresses.	~~Providers need this for look up and contact purposes, e.g., when attempting to locate a client or family member for clinical communications.~~	**2**		M	H		
F-02	**2.003**	The system shall be able to maintain client contact/relationship information such as emergency contact and parents or guardians of children with effective dates. Includes ability to designate type of relationship and contact information.		**2**					
F-02	**2.004**	The system shall be able to import, create, review, modify, delete, and inactivate demographic information about the client.		**2**		H			
F-02	**2.005**	The system shall store demographic information in the client health record in separate discrete data fields, such that data extraction tools can retrieve these data.		**2**		M	H		
F-02	**2.006**	The system shall allow user to define additional fields to collect client demographic data required for California state-wide reporting.		**2**					
F-02	**2.007**	The system shall allow user to view client demographic data that has been created using an different name, alias, or patient identifying number.		**2**					
F-02	**2.008**	The system shall capture insurance information and responsible persons information including history of effective dates.		**2**					
F-02	**2.009**	The system shall be able to merge client demographic data if a client has more than one identical type data record opened erroneously.	Does not have to be only duplicate data found in both records.	**2**					

F-02	**2.010**	The system shall be able to display and review all data in two similar type client demographic records for the same client, highlighting the data that is different.	This will support determining the correct client demographic information that should exist subsequent to merging two records to one.	**2**					
F-02	**2.011**	The system shall require user confirmation prior to merging any client demographic information.		**2**					
F-02	**2.012**	If two client demographic records are erroneously merged, the system shall provide a mechanism for recreating them as separate records.		**2**					
F-02	**2.013**	The system shall provide a mini-registration process for clients who receive minimal service/treatments, requiring fewer mandatory fields to be completed.		**2**					
F-02	**2.014**	The system shall allow for the capture of limited pre-registration information when full registration cannot be completed.		**2**					
F-02	**2.015**	The system shall be able to store both permanent and temporary client addresses.		**2**					
F-02	**2.016**	The system shall be able to retrieve client information by: Client name, Client identification number, date of birth, social security number, or alternate name.	Examples of alternate names: Alias, maiden name, or prior legal name.	**2**					
F-02	**2.017**	The system shall allow the user to efficiently navigate between client registration and other screens without loss of registration data already inputted.	Examples of other screens: Scheduling, billing, client identifier lookup, and service/treatment records lookup.	**2**					
F-02	**2.019**	The system shall provide the ability for the client to enter in their demographic, insurance information, family history, social history and prior medical history via an in-office kiosk.		**2**					
F-15	**15.001**	The system shall be able to capture scanned paper consent documents (covered in DC.1.1.3.1).		**2**		H			
F-15	**15.002**	The system shall be able to store, display and print client consent forms.	Example: Consent forms stored in the computer which are capable of being signed by the client with either an electronic pen or a digital signature once widely available.	**2**		M	H		

F-15	15.003	The system shall allow clients to electronically sign consent forms using California DMH approved digital signature standards. Electronically signed consent forms shall be maintained within the client health record.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	2					
F-15	15.004	The system shall allow secure consents and authorizations to be electronically received for immediate review.		2					
F-15	15.005	The system shall be able to store and display administrative authorizations (e.g. privacy notices).	Needed for HIPAA. Scanned copy is acceptable for 2007.	2		M	H		
F-15	15.006	The system shall be able to store and display client consents associated with a specific clinical activity and be able to link to that event in the client's electronic chart.		2		M	H		
F-15	15.007	The system shall be able to chronologically display consents and authorizations.	This includes consents and authorizations relative to PHI and service/treatment authorization.	2		M	H		
F-15	15.009	The system shall notify users of missing or expired authorizations for service/treatment during the data entry process.	Moved from 30.008	2					
F-20	20.001	The system shall be able to create referral orders with detail adequate for correct routing.	This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists, and other non-medication, non-clinical order. Adequate detail includes but is not limited to: • Date • Patient name and identifier • "Refer to" specialist name, address and telephone number • "Refer to" specialty • Reason for referral • Referring physician name	2		M	M	H	

F-20	20.002	The system shall record user ID and date/time stamp for all referral related events.	Necessary for medico-legal purposes. Security	2		M	M	H	
F-20	20.003	The system shall track consultations and referrals.		2					
F-20	20.004	The system shall be able to print consultation and referral forms.		2					
F-24	24.001	The system shall be able to document verbal/telephone communication into the client record.		2		H			
F-24	24.003	The system shall support messaging between users.	Results and other client data could be included. As clarification, messaging is defined as any text string sent from one person to another in the office.	2		H			
F-26	26.001	The system shall be able to maintain a directory of all clinical personnel who currently use or access the system.	See CA. E.H.R. Behavioral Health Security Criteria	2		H			
F-26	26.002	The system shall support the collection of several user-defined clinician identifiers such as location, credentials, language, days and times worked, and specialties. Credentialing and certification data shall include effective and expiration dates.	Identifiers include credentialing such as state licensure (MD, MFCC, LCSW, MFT, LPT. Etc.) DEA, NPI, and UPIN numbers. This directory may be the same as that in criterion #1 for this functionality.	2		H			
F-26	26.003	The system shall provide validation at the point of service entry that the rendering provider is credentialed to provide the service/treatment.	For example, mental health worker is not credentialed to perform medical medication support service/treatments.	2					
F-26	26.004	The system shall be able to maintain a directory that stores user attributes required to determine the system security level to be granted to each user.	This directory may be the same as that in criterion #1 for this functionality.	2		H			
F-26	26.005	The system shall allow authorized users to update the directory.		2		H			
F-26	26.006	The system shall be able to create and maintain a directory of clinical personnel external to the organization who are not users of the system to facilitate communication and information exchange.	This directory may be the same as that in criterion #1 for this functionality.	2		H	L	H	
F-26	26.007	The system shall support the development of user-defined screens to register, track and report on Provider Organizations and Individual Clinicians that contract with the counties.		2					
F-26	26.008	The system shall support managing data from both contracted clinicians who are part of the external provider network and employee clinicians who staff the county clinics, 24-hour facilities, and community-based programs.		2					

F-26	26.009	The system shall supports the assignment of registered providers (internal or external) to specific fee schedules, specific health plans, specific procedure codes, or groupings of these attributes in a manner that is easy to set up and manage on an ongoing basis.		2					
F-27	27.001	The system shall display a schedule of client appointments, populated either through data entry in the system itself or through an external application interoperating with the system.	Displays are intended to be restricted to authorized viewers.	2		H			
F-27	27.002	The system shall interface to a front-desk environment electronic staff scheduler common to busy public sector clinic settings.	The system supports common inquiries such as “find first available appointment for Dr. X”.	2					
F-27	27.003	The system shall support a user-friendly maintenance of an electronic staff scheduler, noting staff available and non-available hours.		2					
F-27	27.004	The system shall interface to an electronic staff scheduler with daily rosters of appointments and “chart pull” lists that can be generated on demand.		2					
F-27	27.005	The system shall interface to a flexible electronic staff scheduler that allows appointment scheduling several months in advance to accommodate medication management and other service/treatments.		2					
F-27	27.006	The system shall interface to an electronic staff scheduler that allows entry of recurring appointments.		2					
F-27	27.007	The system shall interface with an electronic scheduler that makes appointments for clinicians, rooms, other facilities, and vehicles.		2					
F-27	27.008	The system shall interface with common third-party available appointment scheduling or calendaring software.		2					
F-27	27.009	The system shall allow a user to create or select a provider/client appointment by usage of the following parameters:: Client identifier, date, next available appointment date, time of day, type of visit, provider(s) availability, interpreter availability, location, room, or special equipment.		2					
F-27	27.010	The system shall allow comment entry during appointment creation. As appropriately authorized, this comment shall be viewable, or printable on all scheduler outputs.		2					
F-27	27.011	The system shall be able to enter a client’s reason for requesting appointment (60 characters minimum) when scheduling an appointment.		2					
F-27	27.012	The system shall be able to book one or multiple appointments into an appointment slot.		2					

F-27	27.013	The system shall be able to define the multiple/overbooking limits.		2					
F-27	27.014	The system shall warn the user when the expected maximum number of clients has been appointed to the slot and allows overbooking.		2					
F-27	27.015	The system shall be able to modify an appointment to change the required amount of time allotted. This change affects only the particular day's schedule for the specified provider/clinic.		2					
F-27	27.016	The system shall inform the user of conflicting appointments on the schedule for the specified client.		2					
F-27	27.017	The system shall allow the user to create, modify, or delete types of appointments and to allocate an estimated amount of provider/clinic time needed for each appointment type.		2					
F-27	27.018	The system shall allow the user to designate time frames during which individual providers or clinic resources are not available.		2					
F-27	27.019	The system shall allow the user to book an appointment or generate a reminder for an appointment up to one year in the future.		2					
F-27	27.020	The system shall allow the user to view schedule appointments by scrolling backwards as well as forwards through schedule appointments.		2					
F-27	27.021	The system shall assist the user in coordinating appointments with multiple providers addressing multiple problems during one visit.		2					
F-27	27.022	The system shall allow users to search for reserved blocks of time.		2					
F-27	27.023	The system shall allow for override of reserved blocks with other visits, and can place time restrictions on blocks (e.g., can only be scheduled one day in advance.)		2					
F-27	27.024	The system shall be able to cancel a specified appointment that has been booked and to specify the reason for the cancellation.		2					
F-27	27.025	The system shall make a canceled appointment slot available immediately for rescheduling.		2					
F-27	27.026	The system shall be able to cancel all appointments scheduled for a provider in a selected timeframe and to print a report with contact information for all clients affected by the cancellation.		2					
F-27	27.027	The system shall be able to generate mailing labels and reminder letters to clients for missed, canceled, scheduled or rescheduled appointments.		2					

F-27	**27.028**	The system shall allow the user to view, cancel, and reschedule all appointments for the client.	Especially useful, when a client misses or cancels the first of a series of appointments.	**2**					
F-27	**27.029**	The system shall allow display of all future appointments for a given client or group of clients. For each appoint, this display shows, at a minimum, the following: Provider/clinic, appointment date, appointment time, appointment duration, appointment comment (30 characters minimum), client's reason for making appointment, type of visit, special equipment or room needed, client's account balance, client's payor eligibility(ies).		**2**					
F-27	**27.030**	The system shall allow viewing of a provider's/clinic's schedule either as a display or in hardcopy form. This output shows one day at a time, week-at-a-glance, or month at-a-glance.		**2**					
F-27	**27.031**	The system shall allow viewing of a schedule of clinic resource requirements on demand.		**2**					
F-27	**27.032**	The system shall allow printing of the day's schedule for a specified site, in sequence by appointment time.	Output shall show at least the following data for each appointment: Client name, list of names for group visit, client chart number(s), guarantor name and relationship, client(s) phone number(s), appointment time, appointment comment, client's reason for making appointment, provider name(s), client account status indicator or code, client account balance, date of last payment, and new client indicator.	**2**					
F-27	**27.033**	The system shall provide schedule lists able to be sorted by: Client name , user-selected date range, new clients, walk-ins, and no-shows.		**2**					
F-27	**27.034**	The system shall allow the system manger to specify a schedule template which outlines the typical week's available appointment slots and specifies a visit type, duration, and expected maximum number of clients for each slot. Slots are available for same-day visits.		**2**					
F-27	**27.035**	The system shall allow a system manager to enter and edit a list of holidays in the system and thereby remove these days from all available schedules.		**2**					
F-27	**27.036**	The system shall allow a system manager to enter and edit a list of leave days during which a particular provider shall not be available for appointments.		**2**					

F-27	27.037	The system shall be able to produce a chart pull list for each site. The chart pull list shows the following data, at a minimum for each appointment: Client name, client chart number, client date of birth, client gender, client appointment date/time, client telephone number and address, provider name.		2					
F-27	27.038	The system shall maintain a client waiting list, which can be called up when a client cancellation occurs.		2					
F-27	27.039	The system shall register attendance for the schedule appointment when the client's visit to the clinic is entered.		2					
F-27	27.040	The system shall produce follow-up address labels for user-selected clients.		2					
F-27	27.041	The system shall produce a report of patient who missed appointments (a "no show" report) in a user-selected date/time period.		2					
F-27	27.042	The system shall maintain a history of clients that miss and cancel appointments and can produce a report of contact information for these clients including reasons for cancellations.		2					
F-27	27.043	The system shall be able to generate letters to clients reminding them of their scheduled appointments.		2					
F-27	27.044	The system shall be able to print a charge ticket (super bill) before the appointment or when the patient arrives and checks in.		2					
F-27	27.045	The system shall allow the user to create or edit multiple reminder and/or follow-up letters generated by the scheduling module so that letters can be produced in the appropriate language for selected patients.		2					
F-27	27.046	The system shall print on scheduling output client co-payment amount due, service/treatment authorization expiration date and /or insurance expiration date.		2					
F-28	28.001	The system shall be able to generate reports of clinical and administrative data using either internal or external reporting tools.	Needed for pay for performance, quality improvement activities. All data that is entered in a structured format shall be individually reportable.	2		M	H		
F-28	28.002	The system shall be able to generate reports consisting of all or part of an individual client's health record (e.g. client summary).	Report format may be plain text.	2		H			
F-28	28.003	The system shall be able to generate reports regarding multiple clients (e.g. group therapy).	Any disease registry might be included.	2		M	M	H	

F-28	28.004	The system shall provide users the ability to specify report parameters (sort and filter criteria) based on various variables.	Example variables are: 1) client demographic and clinical data (e.g., all male clients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication). Minimum demographic data are age and gender.; 2) date ranges; 3) program type; 4) Organizational department; 5) Provider.	2		M	H		
F-28	28.005	The system shall be able to access reports external to the EHR application. ?????	For example, printed output, export to a file, etc.	2		H			
F-28	28.006	The system shall be able to produce reports based on the absence of a clinical data element (e.g., a lab test has not been performed or a blood pressure has not been measured in the last year).		2		L	L	H	
F-28	28.007	The system shall be able to save report parameters for generating subsequent reports.		2		M	M	H	
F-28	28.008	The system shall be able to modify one or more parameters of a saved report specification when generating a report using that specification.		2		M	M	H	
F-28	28.009	The system shall be easily configured to allow creation of a variety of outcome measurement instruments.	Locally defined as well as third party licensed scoring protocols can be used to summarize outcome instrument data.	2					
F-28	28.010	The system shall allow third party licensed instruments to be incorporated into the system for authorized use. Clinical review of outcome score trends over time is available as on-line queries for clinical decision-making.		2					
F-28	28.011	The system shall allow on-line clinical review of outcome score trends over time.	This capacity is intended to support clinical decisions.	2					
F-28	28.012	The system shall provide report capability relevant to all requirements listed in this document.	What does this mean?	2					
F-28	28.013	The system shall have the option of outputting reports to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc.		2					
F-28	28.014	The system shall allow standard reports to be copied, edited and added to the reports menu with a new report name.		2					
F-28	28.015	The system shall have standard management reports that provide a variety of management views such as monthly trend reports, clinician comparison reports, program costs, etc.		2					

F-28	**28.016**	The system shall supports the collection, compilation, reporting and analysis of the California-mandated Performance Outcome System (POS) client outcome and satisfaction reports including: the Youth Services Survey (YSS), Youth Services Survey for Families (YSS-F), MHSIP Consumer Survey, and California Quality of Life (CA-QOL).		**2**					
F-28	**28.017**	The system shall support the reporting and data analysis of the county's quality assurance programs.	Quality Assurance: The development and production of reports based on payor and county identified performance and outcome measures for access, assessment, service/treatment planning, service/treatment delivery, etc. Also aids random chart sampling and review processes.	**2**					
F-28	**28.018**	The system shall support the reporting and data analysis of the county's quality improvement programs.	Quality Improvement: The development and production of reports that track and trend quality measures over time and can support the identification of variation that is material and statistically significant.	**2**					
F-28	**28.019**	The system shall support the reporting and data analysis of the county's utilization review programs.	Utilization Review: The development and production of reports that track utilization throughout the county and identify specific clients, clinicians, service/treatments, and/or programs that are above or below user-designated trigger thresholds.	**2**					
F-28	**28.020**	The system shall include an integrated, user-friendly report writer that has the capability of reporting on any combination of data fields in the entire system including user-defined fields; can perform multi-layered sorts and selects; has the ability to utilize wild cards in any data position of a field to select items; has the ability to compute on any field or combination of fields.		**2**					
F-28	**28.021**	The system's report writer shall generate both ad hoc query-type results and formatted reports whose production can be scheduled, produced and distributed electronically on an ongoing basis.		**2**					

F-28	**28.022**	The system 's report writer shall be integrated such that the running of reports against the production database will not create noticeable degradation in the response time of staff that are entering transactions and using the system's various lookup features.		**2**					
F-28	**28.023**	The system's report writer shall all the user to output results to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc.		**2**					
F-28	**28.024**	The system shall allow any interfaced external SQL-compliant third-party report writer applications such as Crystal Reports, Microsoft Access, or R&R Report Writer to report on any combination of data fields in the entire system including user-defined fields.		**2**					
F-28	**28.025**	The system shall support a letter writing/mail merge function where third party word processing programs such as Microsoft Word can be integrated with the system to produce letters to clients, clinicians and other parties.		**2**					
F-28	**28.026**	The system shall support letter templates to be added to system menus and automatically generated based on Workflow Management rules or components.	Examples include the generation of a referral letter to clinician and client when a referral is created, and generation of a follow-up letter when an appointment is recorded as a missed appointment.	**2**					
F-28	**28.027**	The system shall support the development of standard data rectangles based on predefined views that can be exported to common third party products such as Microsoft Excel and Microsoft Access.		**2**					
F-28	**28.028**	The system shall mirror the production database to a reporting server, which uses the Integrated Report Writer and/or an Alternative Report Writer to produce user-developed reports and ad hoc queries		**2**					
F-28	**28.029**	The system shall supports the extraction, transformation, and loading of all data from the system into a Data Store containing denormalized and summarized data, which is used for data analysis and reporting.		**2**					
F-28	**28.030**	The system shall have user-friendly ability to maintain and manage the extraction, transformation and loading processes related to a Data Store during system data dictionary management.		**2**					
F-28	**28.031**	The system shall have documentation which includes a complete data dictionary and Entity Relationship Diagram of all of the tables, table relationships, fields, and field attributes.		**2**					

F-28	28.032	The system shall support internal or alternative report writers drill-down reporting that allow users to examine the underlying data behind figures on the report.		2					
F-28	28.033	The system shall allow users to schedule report production requests for regular periodic processing according to specified criteria such as one or more times per day, weekly on specified day, monthly on first day of month and fiscal period, etc. Specification of data ranges to be included in reports shall be allowed to differ from the scheduled date/time of the execution of the report.		2					
F-28	28.034	The system shall provide predefined views of data sets that merge data from multiple tables into logical reporting groupings to assist non-technical users in creating new standard, management, and ad hoc reports. The system supports the development of views based on groupings of client attributes such as user-defined population cohorts, geographic clusters of zip codes, groupings of client eligibilities, etc. Views can include core fields as well as any user-defined field added to the system.	Example views include Clients, Clinicians, service/treatments, and Authorizations.	2					
F-28	28.035	The system shall support the development of views based on groupings of client attributes such as user-defined population cohorts, geographic clusters of zip codes, groupings of client eligibilities, etc.	Views can include core fields as well as any user-defined field added to the system.	2					
F-28	28.036	The system shall efficiently interface with bi-directional reporting transfer of data with state and county systems as well as with other business associates.		2					
F-28	28.037	The system shall have reporting interfaces that support healthcare application-level transaction standards including, but not limited to HL-7 and ASC X12N; support the translation of data sets based on pre-defined translation code tables; support the development of error-checking routines, flagging via error reports, and the ability to readily resolve non-matching data.		2					
F-28	28.038	The system shall allow trained county staff to maintain and modify reporting interfaces in response to specification changes from payors and business associates.		2					
F-28	28.039	The system shall generate an evaluation survey (scheduled and on-demand) that shall record patient satisfaction.		2					
F-28	28.040	The system shall support real-time or retrospective trending, analysis, and reporting of clinical, operational, demographic or other user-specified data.		2					

F-28	28.041	The systems shall produce reports of usage patterns.		2					
F-28	28.042	The system shall able to perform automatic cost analysis for courses of drug service/treatments.		2					
F-28	28.043	The system shall allow users to develop utilization, statistical and productivity reports on user-determined data fields.		2					
F-28	28.044	The system shall able to produce population-based studies based on flexible, end-user modifiable criteria.		2					
F-28	28.045	The system shall provide that ability to produce scheduled and on-demand case mix reports.		2					
F-28	28.046	The system shall have a tracking mechanism for assessments, service/treatment plans and updates, progress notes, discharge summaries for reminders in the form of a tickler list to the staff member involved.		2					
F-28	28.047	The system shall able to create reminders to clients, particularly for missed appointments or reminders for upcoming appointments.		2					
F-30	30.016	The system shall provide user immediate data entry error notifications with data entry functions..		2					
F-30	30.021	The system shall support the efficient management of group service/treatments. Participants in the group may be coordinated by several different teams within the same agency.	Groups can easily be created, clients added and deleted from particular groups. When service/treatments are entered for a group, all group members are displayed for rapid data entry.	2					
F-30	30.022	The system shall allow for a therapist and co-therapist to have different billing times including different documentation time per client.		2					
F-30	30.023	The system shall support that participants in a group therapy may be coordinated by several different teams within the same agency.		2					
F-30	30.027	The system shall be able to flag, prevent or suspend service/treatment entry outside scope of practice. (i.e. CBT..)	Moved from Administrative Workflow 43.036 . Review again	2					
F-31	31.002	The system shall be able to select an appropriate CPT Evaluation and Management code based on data found in a clinical service/treatment.	May be accomplished via a link to another application.	2		H			
F-31	31.003	The system shall have the ability to provide assistance in selecting appropriate billing codes based on codified clinical information in the service/treatment.	Criterion satisfaction will require that the system can automatically count elements in the history and examination documentation to accomplish this calculation. MDM complexity will still require specification by the provider/coder.	2		L	L	H	

F-31	31.004	The system shall provide the ability to link the most current procedure code with the current service/treatment plan.		2					
F-31	31.005	Charge Capture: The system shall post charges for more than one day for one patient on one screen.		2					
F-31	31.006	Charge Capture: The system shall automatically capture of Evaluation and Management (E&M) codes based on clinical data in the EHR based on rules.		2					
F-31	31.007	Charge Capture: The system shall adhere to Correct Coding Initiative (CCI) and Local Medical Review Policy (LMRP) edits		2					
F-31	31.008	Charge Capture: The system shall adhere to Correct Coding Initiative (CCI) and Local Medical Review Policy (LMRP) edits		2					
F-31	31.009	Charge capture: The system shall provide base line charge capture and the ability to submit the charges to a current or future practice management system.		2					
F-31	31.010	Charge capture: The system shall provide E & M coding guidelines that are designed to insure that the actual charges match the clinical charting. [Note: Need help here – more Coalition language? – UMDAP etc.]		2					
F-31	31.011	Charge capture: The system shall provide charge capture for both nurses and physicians following the 1997 E & M coding requirements.		2					
F-31	31.012	Charge capture: The system shall track the number of points per E & M coding category and provides the provider with a one page summary of the appropriate E & M code. [Note: Would change this to include the partial billing by minutes for group therapy as noted in the Coalition documents.]		2					
F-31	31.013	Charge capture: The system shall provides nationally recognized, practice customized E & M coding tied to the patient's specific healthcare plan for maximizing charge capture via pre-authorization alerts and guidelines.		2					
F-31	31.014	Charge capture: The system shall provide advice in charge capture based on best practices, practice guidelines and reports variances from guidelines.		2					
F-32	32.001	The system shall be able to display eligibility obtained from client's insurance carrier, populated either through data entry in the system itself or through an external application interoperating with the system.	The EHR need only provide information for the physician as to whether the client is covered by that insurance plan. This can be accomplished by a text note following telephone verification.	2		L	L	H	
F-32	32.002	The system shall be capable of electronically receiving and displaying prescription benefits eligibility information.	Will be required by e-prescribing	2		L	L	H	
F-32	32.003	The system shall support monthly loading of the Medi-Cal Eligibility Determination System (MEDS) files from the state.		2					

F-32	32.004	The system shall assure that all eligible enrollees have a new record added to the county system for Medi-Cal eligibility each month, including all retroactive additions to Medi-Cal.	The eligibility system shall maintain eligibility records for all county eligibles in the state monthly download file, not just individuals who are enrolled as clients.	2					
F-32	32.005	The system shall be capable of compliance with the ASC X12N 270/271 - Eligibility for a Health Plan and ASC X12N 834 - Enrollment and Disenrollment formats.	To be used for benefit eligibility determination in Medi-Cal, Medicare, Insurance, and other third party payor systems.	2					
F-32	32.006	The system shall support evaluation of third party payor eligibility for registered clients.		2					
F-32	32.007	The system shall support monthly , or greater frequency, determined by the county, Medi-Cal eligibility evaluation of registered clients		2					
F-32	32.008	The system will allow users the option of updating client insurance records automatically or through computer-assisted manual updates when: 1) an automated eligibility process identifies clients where no prior eligibility had been determined ; 2) where the eligibility status has changed, including retro-active updates for clients previously served,	The process shall include assigning or updating the cascade level of insurance plans that have been changed for a client, identifying clients who have lost their insurance coverage, and determining how previous billings shall be adjusted.	2					
F-32	32.009	The system shall support the manual on-line review and update of insurance records for clients with various special handling conditions including: a partial eligibility match requiring investigation, Medi-Cal Share of Cost responsibility, CMSP eligibility, other state aid codes, Medicare, private insurance, and Medi-Cal clients with a different responsible county. Changes made through the automated insurance eligibility determination process shall be supported with a complete audit trail.		2					
F-32	32.010	The system shall support a real-time interface to the Medi-Cal Point of Service MEDS database for viewing a client's current eligibility status for Medi-Cal and other included payors.		2					
F-32	32.011	The system shall allow a user to poll the Medi-Cal Point of Service MEDS database and then easily update a client's eligibility and insurance coverage records if the coverage has changed.	For Medi-Cal clients this includes entry of the Medi-Cal Eligibility Verification Code (EVC) or, in the absence of an EVC, entering the Primary Aid Code and County Code to support the eligibility status.	2					
F-32	32.012	The system shall support easy identification and clearance of a client's Share of Cost obligation, ensuring that those service/treatments are not billed to Medi-Cal.		2					

F-32	32.013	The system shall support easy access to a client's locally stored eligibility records for eligibility lookup from various components and modules including Call Logging, Appointment Scheduling, Registration, etc.		2					
F-32	32.014	The system shall provide a financial assessment screening process that collects appropriate information regarding indigent clients who may be potentially Medi-Cal eligible. Potential eligibility criteria may be configured by the system administrator in support of current California eligibility criteria.		2					
F-32	32.015	The system shall efficiently integrate Medi-Cal eligibility assessments processes with eligibility referral systems.	See Category 24 for eligibility referral support.	2					
F-32	32.016	The system shall support the collection of data required for the support of various pharmaceutical company indigent patient, "Patient Assistance Programs."	Moved from Order Medication: 11.042.	2					
F-32	32.017	The system shall be able to generate drug-specific "Patient Assistance Programs" applications forms to request medications at no cost from manufacturers.	Moved from Order Medication: 11.043.	2					
F-32	32.018	The system shall support the configuration of multiple "Patient Assistance Programs" application forms that shall be associated with specific medications.	Moved from Order Medication: 11.044.	2					
F-32	32.019	The system shall track the submission of "Patient Assistance Programs" forms and the status tracking of pending applications.	Moved from Order Medication: 11.045.	2					
F-32	32.020	Eligibilty Checking: The system shall be able to perform eligibility checking for batches of clients based on who is scheduled in the next 48 hours.		2					
F-32	32.021	Eligibilty Checking: The system shall notify patients of loss of eligibility.		2					
F-33	33.001	The system shall be able to identify by name all providers associated with a specific client service/treatment.	A provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and nurses; the provider is the person who completes the note.	2		H			
F-33	33.002	The system shall be able to specify the role of each provider associated with a client, such as service/treatment provider, primary care provider, attending, resident, or consultant.	This is simply meant as a means to define the provider role. Display of that data is not addressed.	2		L	M	H	
F-33	33.003	The system shall be able to specify the primary or principal provider responsible for the care of a client within a care setting.		2		H			
F-33	33.004	The system shall be able to create a list of all clients who have had an service/treatment with a given provider.		2		M	M	H	
F-40	40.001	The system shall be able to record mandated reporting data during the course of clinical care.	All mandated reports .	2		H			

F-40	40.002	The system shall be able to import XML Schema definition (XSD) files as provided by DMH.	MHSA Reporting	2		H			
F-40	40.003	The system shall incorporate the XSD as provided by DMH into the EHR. - talk to Lori/Marini	MHSA Reporting	2		H			
F-40	40.004	The system shall provide functionality to produce reports based on absence of mandated data elements.	All mandated reports	2					
F-40	40.005	The system shall provide a mechanism to add data based on reports that identify the absence mandated data elements.	All mandated reports	2					
F-40	40.006	The system shall generate error or suspension reports prior to sending a mandated report to DMH.	All mandated reports	2		H			
F-40	40.007	The system shall allow the user to specify the output format for mandated reporting. (e.g.. XML, CSV,etc).	All mandated reports	2					
F-40	40.008	The system shall produce reports in accordance with the record layouts required by DMH.	CSI Reporting	2					
F-40	40.009	The system shall cross walk local codes to values required by mandated reporting.	All mandated reports for example ethnicity code,	2					
F-40	40.010	The system shall efficiently meet California CSI and OSHPD Inpatient reporting requirements	County requirements for tracking key inpatient data include date of admission, referring provider, inpatient case manager, treating psychiatrist, outpatient authorization type, outpatient case manager, and date of discharge, admit and discharge diagnosis, legal status, etc.	2					
F-40	40.011	The system shall validate mandated reporting elements based on the date of service/treatment.	Example is: CSI Reporting - DMH requirements for service/treatment records shall be met.	2					
F-40	40.012	The system shall provide entry, creation and compliance tracking of the California Treatment Authorization Requests or similar locally defined authorization or notification forms, which are generated for inpatient admissions and submitted to the State's inpatient fiscal intermediary or similar party.		2					
F-40	40.013	The system shall track episodic data during the inpatient stay such as utilization review notes and user-defined checklists and can produce daily census and bed statistics reports for clients being managed by the county.		2					
F-41	41.001	The system shall appropriately adjudicate, reject, receive, and integrate ASC X12N 837 - Health Claims or Equivalent Encounter Information from external providers.		2					
F-41	41.002	The system shall allow manual entry of external Health Claims or Equivalent Encounter Information.		2					

F-41	41.003	The system EHR related claim adjudication shall be automated and adjudicate on a per claim basis.		2					
F-41	41.004	The system EHR related claims shall be adjudicated on user-defined rules including payor eligibility, whether other insurance plans are primary, the existence of an appropriate authorization, coverage for the specific service/treatment, service/treatment by an authorized provider, and covered diagnosis.		2					
F-41	41.005	The system shall efficiently integrate with systems that provide ASC X12N 835 - Healthcare Payment and Remittance Advice format reports.		2					
F-41	41.006	The system shall be able to forward External Provider ASC X12N 837 Health Claims to all claim payors.	This includes Short Doyle Medi-Cal, Medicare, Insurance, and other providers (such as other counties).	2					
F-41	41.007	The system shall efficiently allow for pending claims review and subsequent approval or denial of further claim submission.		2					
F-41	41.008	The system shall efficiently integrate with an accounts payable system that supports EHR related claiming.		2					
F-41	41.009	The system shall have ability to produce paper and electronic EOB and offer flexibility for user-defined letters to accompany EOBs.		2					
F-41	41.010	The system shall support the entry of claim adjustments where claims that have been entered, adjudicated, approved and paid can be reversed and credit balances cleared. These adjustments shall also be included in the Remittance Advices for specific providers/facilities.		2					
F-41	41.011	The system shall require all EHR claim payments and adjustment entries, including reversals, be supported by an audit trail, user-friendly screen views and reports.		2					
F-41	41.012	The system shall support the entry of payment and denial information from providers related to coordination of benefits where the county is not the primary payor; in many cases this is required prior to county payment of their secondary or tertiary responsibility.		2					
F-41	41.013	The system shall maintain claims payment history for all claims processed through the EHR claims processing module. These payments shall be supported by an audit trail, user-friendly screen views, and reports.		2					
F-41	41.014	The system shall coordinate all providers EHR related claims against claim payment limits.		2					

F-41	**41.015**	The system shall track all providers EHR related claim limits by vendor and payor source with user-friendly summary and detail information screen views and reports.		**2**					
F-41	**41.016**	The system shall generate related IRS Form 1099 documents each calendar year end.		**2**					
F-41	**41.017**	The system shall supports multiple contractor agreements detailing services funded by multiple payors with differing benefit designs and multiple provider reimbursement systems such as case rate, fee for service, capitation, and fixed fee payments.	Different benefit designs can include or exclude certain service/treatments based on diagnosis, coverage, or other attributes. A single provider can have multiple fee schedules based on health plan coverage or population served, including enhanced rates for service/treatments based on county-specific criteria such as language. Fee schedules have start and end dates, with history saved to support proper payment of late claims submitted after the end date of a given fee schedule.	**2**					
F-41	**41.018**	The system shall support payor reimbursement due to A/R adjustments.	Reimbursements may be due to overcharges, overpayments, incorrect service/treatment entry, incorrect software application routines, therapeutic adjustments, etc.	**2**					
F-42	**42.001**	The system shall integrate service/treatments provided with California Mental Health claiming requirements.	Reporting requirements include translations for mode of service code, minutes of service, number in group, clinician ID, and co-therapist ID. They also include following appropriate claiming rate protocols. Provider code will be either a numeric or an alphanumeric code which may translate to an individual private practice clinician, or an agency composed of several clinicians. The agency may be county operated or a contract facility. All such organizations or entities will have a provider code.	**2**					

F-42	**42.002**	The system shall have the ability to translate the California claiming requirements into the ASC X12N 837 - Health Claims or Equivalent Encounter Information format for billing.	Reporting requirements include translations for mode of service code, minutes of service, number in group, clinician ID, and co-therapist ID.	**2**					
F-42	**42.003**	The system shall receive, and integrate ASC X12N 835 - Payment and Remittance Advice data for internal providers claims adjudication.		**2**					
F-42	**42.004**	The system shall receive, integrate, and forward ASC X12N 835 - Payment and Remittance Advice data to external providers.		**2**					
F-42	**42.005**	The system shall correct and re-submit ASC X12N 837 - Health Claims, as appropriate.	This requirement includes correction and resubmission of claims denied by the state.	**2**					
F-42	**42.006**	The system shall void and/or replace previously submitted ASC X12N 837 - Health Claims, as appropriate.		**2**					
F-42	**42.007**	The system shall allow manual entry of internal and external receivables EHR service/treatment related Information.	This might be accomplished through linkage to manual service/treatment data entry. (See FR …)	**2**					
F-42	**42.008**	The system shall produce paper-based claims (such as HCFA-1500, UB-92 and user-defined formats) for any EHR service/treatment transaction on-demand or in a batch mode. This includes claims which are forwarded electronically to the county from contract providers for submission to payors and the corresponding forwarding of remittance advices back to the contract providers.		**2**					

F-42	**42.009**	The system shall support required billing rules for specific service/treatments and programs. Detail on these rules may be found in a variety of sources such as: CA DMH Information Notices; CA DMH Letters; CA DMH HIPAA 837 Companion Guide; CA DMH CSI manuals; future release of CA DMH SD-MC Provider Resource Manual; Federal OMB Circulars; and Federal Medicare Guidelines.	Examples of California billing requirements protocol which need appropriate handling: 1) Group Therapy billing - both groups with mental health clients only and groups with both mental health and non mental health clients; 2) Multiple staff billing on one client, such as during a case conference, or crisis event; 3) Medi-Cal service/treatments "lock-outs" ; 4) Billing all payor sources at the same rate; 5) Net Billing Medi-Cal after billing other payors such as Medicare; 6) Healthy Families population claiming; 7) AB3632/26.5 population claiming; 8) Restricting CalWorks client billing to SD-MC; 8) Medi-Cal Share of Cost applicability to SD-MC and client payors; 9) Client UMDAP based claims.	**2**					
F-42	**42.010**	The system shall be user-configurable to allow certain authorization types in the Authorization Management component to control whether an entered service/treatment is billed to a third party payor.	An example is if a provided service/treatment does not fall within the parameters of an existing authorization for a client (e.g. date range, provider, service/treatment code) the claim will be pended and listed on an error report or tickler system for follow-up.	**2**					
F-42	**42.011**	The system shall ensure that AB3632 service/treatments billed to government educational agencies are configurable to the service/treatments authorized in a youth's Individualized Education Plan (IEP) authorization.	Authorization requirements are bound by client enrollment, service/treatment type, service/treatments authorized, and authorization period.	**2**					
F-42	**42.012**	The system shall support multiple payors for a client service/treatment.	Support includes tracking and management of benefit limits, deductibles, copays, and covered and non-covered service/treatments for specific plans.	**2**					
F-42	**42.013**	The system shall support multiple fee schedules by payor including state-specific fee schedules such as the Medi-Cal AB3632 fee for service billing for children identified with a severe emotional disorder via a separate payor source with specific billing/adjust rules for that program.		**2**					

F-42	42.014	The system shall support easy updating of all client data related to payor coverage.	This includes specific plan benefit plan changes which may occur.	2					
F-42	42.015	The system shall support the management of multiple reimbursement methods including fee for service, case rates, per diem, capitation and grant-in-aid, and the bundling and unbundling of service/treatment codes by payor.	For example, certain service/treatments have to be bundle-billed to Medi-Cal, but those same service/treatments shall be individually billed to Medicare and private insurance.	2					
F-42	42.016	The system shall utilize retroactive enrollment data to produce payor claims for service/treatments originally billed to other sources and makes the proper adjustments to the relevant revenue, receivable and adjustment accounts. The system can retroactively bill these plans based on plan-specific retroactivity date limits.	This includes retroactive Medi-Cal, Medicare, and private insurance eligibility updates. Examples of plan-specific retroactive date limits is Medi-Cal service/treatments can be retroactively billed 12 months from the date of service/treatment and Healthy Families 24 months.	2					
F-42	42.017	The system shall support the setup of grant funding sources as quasi-insurance companies where clients who have no other coverage and meet funding sources eligibility requirements can have their service/treatments cascade to either a specific grant source (quasi-insurance company) or to a funding source group that may be billable to multiple grant sources. The system shall be configurable so that these charges can either be posted as outstanding accounts receivables that will be cleared by grantor payments, or automatically written off to a specific adjustment account. The system shall be able to track and report on the grant eligibility of all visits provided to individuals who are eligible for these funds.	Examples are CalWorks, SAMHSA, PATH, AB2034, MSHA FSP, AB3632/26.5 and MIOCR funding sources.	2					
F-42	42.018	The system shall support proper calculation of all client benefit-plan(s) co-pays and deductibles.	This includes integration with the Ca. DMH UMDAP fee schedule client liability calculations.	2					
F-42	42.019	The system shall support adjustments to outstanding client benefit-plan(s) balances.	This includes integration with the Ca. DMH UMDAP client liability adjustments.	2					
F-42	42.020	The system shall provide appropriate and accurate client billing for all outstanding copayments and deductibles.	This includes appropriate adjustment to UMDAP information originating from another provider. This includes client Medi-Cal Share of Cost Liability.	2					
F-42	42.021	The system shall provide HIPAA compliant electronic transmission of all client account receivable information from one provider to another.	This is especially important for A/R data transfer between Ca. counties since a Ca. client UMDAP liability is statewide specific, not provider specific.	2					

F-42	42.022	The system shall prevent Medi-Cal billing for clients with no known Medi-Cal eligibility during the month of service/treatment.	This requirement requires close integration with client Medi-Cal Share of Cost liability processes.	2					
F-42	42.023	The system shall provide user-friendly screen views related to all client co-pays and deductibles transactions.		2					
F-42	42.024	The system shall provide user-friendly reports related to all client co-pays and deductibles transactions.		2					
F-42	42.025	The system shall provide a user-friendly viewable audit trail for all client co-pays and deductibles transactions.		2					
F-42	42.026	The system shall provide a user-friendly reportable audit trail for all client co-pays and deductibles transactions.		2					
F-42	42.027	The system provide support client liability collection processes.	This includes support for documentation of attempts at obtaining client outstanding liability and support for adherence to provider A/R debt transfer protocols ("collections referrals").	2					
F-42	42.028	The system shall provide efficient electronic procedures to support bad debt write-off.		2					
F-42	42.029	The system shall support production of user-defined client billing statements on demand and on a cycle basis (e.g. every month) and has the capability of disabling the production of statements for any client.		2					
F-42	42.030	The system shall support classification of clients into categories for which the user will have control over the decision to print statements.	Examples are: 1) When the cost of billing exceeds the potential revenue to be billed client shall not be sent statements; 2) Clients who have Medi-Cal coverage shall not receive statements.	2					
F-42	42.031	The system shall support the identification and addressing to the correct receivor of the client billing statement.	Examples are: 1) Redirection of client statement to the client/guarantor, the client's conservator, or both.	2					
F-42	42.032	The system shall efficiently support client billing statements with user-defined provider messages.	These messages may be billing warnings, payment thank-you messages, or even care provider messages. The message writing protocols shall be based on provider billing message protocols.	2					
F-42	42.033	The system shall provide user-friendly statements printed in detail or summary format based on user-defined rules.		2					
F-42	42.034	The system shall have a client billing statement audit trail.		2					

F-42	42.035	The system shall provide a user-friendly viewable audit trail for all client billing statements issued.		2					
F-42	42.036	The system shall provide a user-friendly reportable audit trail for all client billing statements issued.		2					
F-42	42.037	The system shall support entry of standard service/treatment fees set by local, state or federal governance and post A/R transactions respectively.	Data supporting the standard service/treatment fees shall be locally defined but may include effective begin and termination dates, fee amount change date, change authorizer, ID of staff who made changes, and BOS date.	2					
F-42	42.038	The system shall support estimated costing of all provider service/treatments rendered (direct and indirect service/treatments).	The estimated cost of a direct service/treatment for a client is typically determined as stated in Standard fee setting requirement above. Estimated cost of either direct or indirect service/treatment is intended to assist the provider in managing or reporting on estimated year end service/treatment or program costs. Usage of this capability will be provider specific.	2					
F-42	42.039	The system shall support correlation of service/treatment fees to the related Statewide Maximum Allowance (SMA) set by the CA DMH.	The SMA is a SD-MC rate cap which is updated annually by CA DMH.	2					
F-42	42.040	The system shall integrate with A/R and G/L posting of contractual allowances and sliding scale adjustments for each service/treatment from all sources at the time of entry based on the billing rules entered for insurance companies and self-pay clients.		2					
F-42	42.041	The system shall support recording contractual allowances or sliding scale discounts adjustments to the standard fees.	Support may be demonstrable for postings to the county's general ledger via hard copy or electronic posting reports, which can be summarized based on user-defined criteria including subtotals by payor, payor class, program, location, etc.	2					
F-42	42.042	The system shall support the entry and proper tracking of multiple user-defined adjustment codes.	Examples of adjustment codes include contractual allowances, sliding scale discounts, incorrect fee postings, therapeutic adjustment authorized by county mental health director, and bad debt write-offs.	2					

F-42	**42.043**	The system shall support manual payment posting to client accounts receivable balances.	Client A/R balances encompass client liability calculations per rendered service/treatment fee and UMDAP rules.	**2**					
F-42	**42.044**	The system shall support issuance of sequentially numbered payment receipts.		**2**					
F-42	**42.045**	The system shall allow the posting of payments to a client account even though there are no related charges.	Payments may be shown as credit balances to be matched with charges at a later date per local county policy.	**2**					
F-42	**42.046**	The system shall support A/R linkage to A/P payments for required payor reimbursement.	Reimbursements may be due to overcharges, overpayments, incorrect service/treatment entry, incorrect software application routines, therapeutic adjustments, etc.	**2**					
F-42	**42.047**	The system shall support electronic posting of the ASC X12N 835 - Healthcare Payment and Remittance Advice to client accounts.		**2**					
F-42	**42.048**	The system shall support controls for reconciling payments entered due to cash receipts.		**2**					
F-42	**42.049**	The system shall support open item accounting that allows posting of payments and adjustments to specific charges/invoices.	http://www.delphipbs.com/help/html/openitemaccounting.htm	**2**					
F-42	**42.050**	The system shall support correct sequential billing of payors ensuring that the sequence is based on both the coverage that the client has and the service/treatments that are covered by the various plans. When Remittance Advices are posted, outstanding charges shall be automatically calculated and upon user confirmation, transferred to secondary and tertiary payors and/or client responsibility. Thereafter, appropriate electronic and paper claim forms shall be produced which include payments received from previous payors.	Examples of sequential payor billings are: 1) Medicare 1st, Private Insurance 2nd; Patient 3rd; 2) Patient 1st and Medi-Cal 2nd	**2**					
F-42	**42.051**	The system shall support that outstanding charges not confirmed and transferred to the next sequential payor remain as an open receivable.		**2**					
F-42	**42.052**	The system shall support that appropriate audit trails are kept of claims that have been sequentially billed to multiple payors.		**2**					
F-42	**42.053**	The system shall support automatic crediting of contractual allowance and other adjustment accounts during payment posting based on predetermined carrier-specific criteria.		**2**					

F-42	42.054	The system shall ensure that revenue and A/R balances do not overstate outstanding amounts by reporting balances for multiple payors simultaneously.		2					
F-42	42.055	The system shall track and report A/R data related to client service/treatments via detailed aged accounts receivable reports with user-defined sort and subtotal criteria including payor, provider, client, program, location, etc.		2					
F-42	42.056	The system shall compute and automatically write off of positive or negative contractual allowance amounts for bills that are covered by capitated or grant-in-aid funding streams.		2					
F-42	42.057	The system shall support screen views for all client accounts that show the transaction history of all charges, payments, and adjustments for all payors for a specified date range.	These screen views shall allow filtering to show the same information for a single payor (including client responsibility).	2					
F-42	42.058	The system shall be able to attach and display user notes to any transaction.	Examples of notes are: 1) Notes regarding collection calls to clients; 2) Client verbal consents re: account payments; 3) Follow up notes to provider staff.	2					
F-42	42.059	The system shall support production of tickler system reports based on the follow-up dates entered into A/R transaction notes.		2					
F-42	42.060	The system shall efficiently support timely completion of the required end of year cost DMH SD/MC Cost Report.	Includes accurate compilation of related units of service, time, charges, payments and classifications accordingly. Classification might be by provider; age; program target population; payor source such as Healthy Families, AB3632/26.5, EPSDT, Medi-Cal, Medicare, Medi-Cal/Medicare Crossovers, Insurance, and indigent; California's mode and service function code structure.	2					
F-42	42.061	The system shall efficiently support timely completion of a monthly, quarterly, and semi-annual projected end of year cost DMH SD/MC Cost Report.		2					
F-42	42.062	The system shall efficiently support timely completion of required monthly, quarterly, and semi-annual grant funding reports.	Examples are PATH, SAMHSA, MIOCR, AB2034, and MHSA grant funding.	2					
F-42	42.063	The system shall have a single-entry system for both on-site and off-site service/treatments.		2					

F-42	42.064	The system shall have the ability for electronic download and upload of data, including third party (e.g., Medicare, Medi-Cal, insurances) and state programs.		2					
F-42	42.065	The system shall support both real-time and batch entry of client service/treatment charges.		2					
F-42	42.066	The system shall be able to record fees collected at the beginning of each visit.		2					
F-42	42.067	The system shall allow for the ability to re-bill errors individually and in batch.		2					
F-42	42.068	The system shall allow re-billing of any unpaid accounts by payor type at the user's choice (e.g., insurance carrier not paid within 60 days and no EOB received).		2					
F-42	42.069	The system shall allow for both primary and secondary insurances to be billed electronically.		2					
F-42	42.070	The system shall maintain fees for all items which the user identifies as billable. This fee schedule has restricted access and can be updated by the system administrator when necessary.		2					
F-42	42.071	The system shall be able to bill FQHC rates or per-diem amount established by the funding third party carrier currently Medicare and Medicaid).	FQHC – Federally Qualified Health Center	2					
F-42	42.072	The system shall allow the ability to establish multiple sliding fee scales, set alternate client fees with a date range when the fee is in effect.		2					
F-42	42.073	The system shall automatically determine the sliding fee category based on family size and income. A review date is established for review of the sliding fee.		2					
F-42	42.074	The system shall be able to pull up all billing related to a specific service/treatment site or for service/treatments billed throughout the agency, and to attribute payments to specific service/treatments.	Display includes claims, payments, denials, re-billings	2					
F-42	42.075	The system shall be able to identify the client's co-payment (sliding fee) as a component of the total amount due (able to identify what is outstanding for insurance billing, for example, and what the client must pay out of pocket.)		2					
F-42	42.076	The system shall be able to determine which payor to submit the bill to based on service/treatments provided (based on procedure code, service/treatment location, payor requirements) or by the priority of the payor as defined in the system.		2					
F-42	42.077	The system shall default the visit diagnosis to the last or the chronic diagnosis based on the preference set by the user.		2					

F-42	42.078	The system shall display the primary, secondary and tertiary insurance for selection during charge entry (defaults to primary) and allows changing insurance assignments as necessary.		2					
F-42	42.079	The system shall prompt the user with the procedure code and fees associated with the selected insurance carrier.		2					
F-42	42.080	The system shall support splitting of global fees into user-defined components.		2					
F-42	42.081	The system shall prevent users from entering procedures to incorrect sites, departments or providers.		2					
F-42	42.082	The system shall have an automated link to benefits determination for Medicare, Medicaid and third-party insurance.		2					
F-42	42.083	The system shall be able to print encounter forms and receipts, giving the client a printed summary of payments and outstanding charges at each service/treatment, listing the procedure charge and the amount of the discount given.		2					
F-42	42.084	The system shall be able to write off balances not covered by selected payors when payment is received (e.g., Medicaid accepted as payment in full.)		2					
F-42	42.085	The system shall allow that specified bills can be generated at any time, e.g., can print individual client bill without waiting to batch bills weekly or monthly.		2					
F-42	42.086	The client billing statement shall include: Client name, client address, client identifier number, provider, program name, dates of service/treatment, procedure codes, prior balance, fees charged since last billing statement, applicable account adjustments, and balance due.		2					
F-42	42.087	The system shall support automatic translation of entered diagnoses and procedure codes to alternate state and third-party payor-mandated coding methodology for reimbursement claim forms.		2					
F-42	42.088	The system shall be able to record the payment schedule by procedure code, by insurance plan, allowing the user to add, edit, and delete tables for most common payors.		2					
F-42	42.089	The system shall allow the user to define the pertinent questions to be asked per payor at intake and throughout service/treatment.	Different payers have different information requirements.	2					
F-42	42.090	The system shall allow the user to suspend billing a client pending a response from a third-party payor. A notation field indicates the reason for the suspension of client billing.		2					

F-42	42.091	The system shall reflect client bills all appropriate account adjustments.		2					
F-42	42.092	The system shall allow the system manager to modify the format of the client or family statements with out vendor intervention.		2					
F-42	42.093	The system shall be able to establish and have bills adjust to a center-specific sliding fee scale policy including; minimum fee by procedure code, minimum fee per visit, minimum fee by department (or some combination of these), sliding fee as a percentage of full charge, ability to identify procedures ineligible for sliding fee.		2					
F-42	42.094	The system shall be able to suppress billing statement in select user-defined situations.		2					
F-42	42.095	The system shall display comments or flags indicating special conditions associated with individual clients or their accounts.		2					
F-42	42.096	The system shall access insurance companies' eligibility files.		2					
F-42	42.097	The system shall interface with the scheduling system so that clerical staff shall receive automated billing messages when clients come for scheduled appointments.		2					
F-42	42.098	The system shall combine and submit on one bill all service/treatments provided to one client on the same day.		2					
F-42	42.099	The system shall use single source billing.		2					
F-42	42.100	The system shall make accessible and able to sort on a date basis a client's entire payment history.		2					
F-42	42.101	The system shall be able to track payments and credit the appropriate program site where the charges occurred.		2					
F-42	42.102	The system shall support development of budget plans and bills first/second party payors according to the budget plan agreement.		2					
F-42	42.103	The system shall be able to post receipts as a batch, with repetitive entries keyed only once.		2					
F-42	42.104	The system shall be able to keep a running total to tie receipts to an intermediary's check and to the total of the bank deposit.		2					
F-42	42.105	The system shall track the status of each outstanding payor balance by the age of the balance (intervals of 30 days up to 150 days) and by whether or not a minimum payment (% of the amount due), a full payment, or no payment have been made against the outstanding balance.		2					

F-42	42.106	The system shall be able to generate aging reports at these 30 day intervals by user-defined categories such as department, payor site.		2					
F-42	42.107	The system shall be incompliance with GAAP.	GAAP – Generally Accepted Accounting Practices	2					
F-42	42.108	The system shall be able to post a receipt to a specific month of service/treatment, oldest balance or to individual open items. It shall provide the flexibility in how receipts are posted. For example; the ability to post the current month's receipts even if the prior month is not closed.		2					
F-42	42.109	The system shall be able to post adjustments to a prior month.		2					
F-42	42.110	The system shall allow global rate adjustments and all affected accounts shall be adjusted automatically.	Example: When fee schedules change.	2					
F-42	42.111	The system shall generate a complete audit trial of all adjustments to billings.		2					
F-42	42.112	The system shall be able to bill multiple payors in the way required (service units, CT codes, etc.).		2					
F-42	42.113	The system shall provide edits in order to prevent entering non-valid data.		2					
F-42	42.114	The system shall be able to use effective dates for certain data (such as procedure codes).		2					
F-42	42.115	The system shall be able to drive billing off of the client records (link to progress note entries).		2					
F-42	42.116	The system shall provide a "tickler system" for tracking the activities associated with managing collection accounts.		2					
F-42	42.117	The system shall produce a report of all credit balances.		2					
F-42	42.118	The system shall be able to update balances due and perform aging of client accounts in real-time when payment is received.		2					
F-42	42.119	The system shall track patient charges, credits and remittance history.		2					
F-42	42.120	The system shall be able to print a day log of all transactions processed by a staff member or site to facilitate cash drawer reconciliation and encounter form tracking.		2					
F-42	42.121	The system shall issue monthly mailing statements that confirm to specifications of the US Postal Service including printing ZIP+4 and bar coding requirements.		2					
F-42	42.122	The system shall display the account status information from accounts receivable via an account status indicator or code on the client registration screens.		2					

F-42	42.123	The system shall include: Real time aging reports, collection note fields for follow up information, collection payment reports by department, collection payment reports by site.		2					
F-42	42.124	The system shall be able to indicate an account is in collection process and the ability to run reports on accounts so designated.		2					
F-42	42.125	The system shall generate template collection letters from data in the collection database.		2					
F-42	42.126	The system shall include reminders that the next letter or action is due for a specific account.		2					
F-42	42.127	The system shall maintain a history of statements mailed to clients, including the date and type of the statement sent.		2					
F-42	42.128	The system shall generate reminder notices to the agency and to clients with expired sliding fee review dates.		2					
F-42	42.129	The system shall be able to bill all payors of a client electronically as well as manually.	Examples: Medicare, Medicaid, CA Department of Mental Health, CA Department of Alcohol and Drug, private pay, insurers and of third party payors.	2					
F-42	42.130	The system shall be able to print special billing forms.	Example: UB92.	2					
F-42	42.131	The system shall be capable of automatically calculating contractual adjustments based on user setup.		2					
F-42	42.132	The system shall be able to post and track capitation payments by insurance carriers.		2					
F-42	42.133	The system shall be able to run revenue projection reports using current census information.		2					
F-42	42.134	The system shall be able to run daily and monthly cash drawer reports (encounter reports).		2					
F-42	42.135	The system shall run revenue reports by various parameters to show amount billed, revenue received, amount outstanding, and amount denied.	Parameter examples: Provider, type of service/treatment, funding source, and program.	2					
F-42	42.136	The system shall be able to resubmit denied claims with appropriate corrections.		2					
F-42	42.137	The system shall be able to transmit valid void and replace HIPAA 837 transactions to all payor sources accepting such transactions.	Examples are: : Client account number, sources of funding available to client, UMDAP liability.	2					
F-42	42.138	The system shall interface with the Registration functions so that at the initial client contact the system can display critical information.	Examples are: : Client account number, sources of funding available to client, UMDAP liability.	2					
F-42	42.139	The system shall link service/treatment transactions and medical/nursing data in order to eliminate redundancy and to ensure that service/treatments billed match services provided.		2					

F-42	**42.140**	The system shall interface the A/R function with the Scheduling function so that the status of a client's account is available: At the time the appointment is made and when the client arrives for service/treatment.		**2**					
F-42	**42.141**	The system shall interface the A/R function with the Registration and Scheduling functions so that the status comments and an account status indicator associated with the client account is displayed.		**2**					
F-42	**42.142**	The system shall immediately reflected all changes to a client's registration information in the A/R data.		**2**					
F-42	**42.143**	The system shall provide an inquiry function that enables the user to view with following elements of an A/R account:	Examples are: service/treatment charges, guarantor information, account status codes, client account balances, third party payor account balances, assignment acceptance, and third party payor effective dates.	**2**					
F-42	**42.144**	The system shall allow detailed financial transactions to be reported or displayed in chronological order by posting date and include various data.	Examples of data are: Date of service/treatment, member of account receiving care, posting date, provider's name, site of service/treatment, transaction amount, claim identifier number, payer, and status of claim.	**2**					
F-42	**42.145**	The system shall sort and print to any printer a patient's account information sorted by pay code (charges, discounts, and payments).		**2**					
F-42	**42.146**	The system shall make available a summary report that shows the last payment date, last payment amount, and credit balance for a patient's account associated with any payor.		**2**					
F-42	**42.147**	The system shall post support double entry accounting.		**2**					
F-42	**42.148**	The system shall distinguish account credits and debits from debit adjustments and credit adjustments.		**2**					
F-42	**42.149**	The system shall allow data entry as on-line or batched. Batched transactions may be optionally edited on-line (additions, changes, deletions) prior to posting transactions to the accounts.		**2**					
F-42	**42.150**	The system shall associate all transactions with the client, the account, the name of the person who posted the transaction, the posting date, the name of the transaction, the dollar amount of the transaction, and the transaction type.		**2**					

F-42	42.151	The system shall associate each charge item with: Date of service/treatment, payer, provider, department/program, procedure code, funding source, site of service/treatment, type of service/treatment, override fee flag, user defined comment field, charges to which payment is applied, payor identifier numbering.	Examples of payor identifier numbering: Client check number and check bank number, State warrant number.	2					
F-42	42.152	The system shall associate each adjustment with: Date of service, provider, department, program, funding source cost center, type of adjustment, comment/notation area.		2					
F-42	42.153	The system shall post third party payments to particular visits designated by the payor as well as to the outstanding balance (as a unit).		2					
F-42	42.154	The system shall provide a journal entry for the general ledger detailing revenue, adjustments, payments, bad debts, refunds by account number (segmented by site and department). The GL entry and A/R reports shall be run at any time after the close of the period and shall not be changed.		2					
F-42	42.155	The system shall be able to automatically write-off accounts based on insurance plan, date of service/treatment, and threshold balance.		2					
F-42	42.156	The system shall be able to post denials with codes into the system electronically.		2					
F-42	42.157	The system shall provide a report to reconcile amounts written off to bad debt.		2					
F-42	42.158	The system shall provide a report to reconcile amounts refunded to clients.		2					
F-42	42.159	The system shall provide a daily transaction log that lists the detail of all the transactions entered each day.		2					
F-42	42.160	The system shall include a daily transaction log with the date and time each transaction is generated.		2					
F-42	42.161	The system shall include a daily transaction log organized by patient name in alphabetical order or by account number; the order is user-defined and may be changed from one accounting period to another.		2					
F-42	42.162	The system shall include a daily transaction log with following detail within each account: Date of service/treatment, posting date, provider's name, transaction description, transaction type, and transaction amount.		2					
F-42	42.163	The system shall generate a bank deposit sheet listing all checks (with bank and check numbers) their dollar amounts, and the total amount for deposit.		2					

F-42	42.164	The system shall generate a cash receipt log (cash and checks) broken out by facility or by program, and/or by provider.		2					
F-42	42.165	The system shall provide an Aged Trial Balance (ATB) report, in alphabetical order by guarantor/payor name that shows all outstanding receivables on all non-zero balance accounts. Aging is presented in 30 day intervals up to 150 days. This report can be run at the user's option in a user-selected date of service/treatment range (i.e., not mandatory to run each month.)		2					
F-42	42.166	The system shall provide an ATB that shows for all accounts with charges in suspense aging of the system amounts by insurer and site.		2					
F-42	42.167	The system shall show include with each account description: Payor's name, account number and telephone number.		2					
F-42	42.168	The system shall have an ATB report that includes totals for the entire practice by age category for guarantor responsibility and for each third-party payor with suspended amounts.		2					
F-42	42.169	The system shall have an ATB report that is sorted by insurance, number of days outstanding, sliding fee type, or credit code.		2					
F-42	42.170	The system shall provide a monthly Outstanding Third-Party Charges report that shows aged totals for all third-party payors. It includes claims currently in suspense by account		2					
F-42	42.171	The system shall have an Outstanding Third-Party Charges report that is sorted by site, by program, and/or by payor.		2					
F-42	42.172	The system shall produce both detail and summary receivable reports by client financial status, by age and amount due, by location, by provider, accounts with credit balances, and overdue accounts that are candidates for collection.		2					
F-42	42.173	The system shall provide an A/R Ledger that is subdivided into non-zero balance and zero-balance accounts; the non-zero balance accounts are shown with the date and/or number of days since the last payment/activity.		2					
F-42	42.174	The system shall provide Revenue Analysis report(s) that break(s) out revenue or gross charges by: Entire system, provider, site, program, payor, cost center, or any combination of these.		2					

F-42	**42.175**	The system shall provide a Detail Revenue Analysis report that must show Adjusted Gross Charges by applying contractual adjustments to Gross Charges. Charge Adjustments are subtracted from Adjusted Gross Charges to arrive at Net Billable Amounts. Adjustments to Gross Charges include Reversal of Charges.		**2**					
F-42	**42.176**	The system shall have a Revenue Analysis Report(s) which can be run on a cash basis showing charges, adjustments, and payments at the time the report is run.		**2**					
F-42	**42.177**	The system shall have a Revenue Analysis Report(s) which can be run on an accrual basis showing charges for prior periods, related adjustments, related payments, and net balances by associated period.		**2**					
F-42	**42.178**	The system shall produce a Capitated Client List that shows insurance information for all clients under capitation.		**2**					
F-42	**42.179**	The system shall produce an Encounters for Patients Without Third Party Coverage report that lists clients' full names, their social security numbers, and all encounters and their associated charges within a user-specified date range for clients that show no insurance coverage on their accounts. This report can be used to check Eligibility for medical reimbursement.		**2**					
F-42	**42.180**	The system shall provide the capability of identifying how much has been billed, where the claims were sent and the current status of the claims.		**2**					
F-42	**42.181**	The system shall provide reports including year-to-date comparisons by insurance company and/or physician or outstanding claims by physician.		**2**					
F-42	**42.182**	The system shall provide billed/allowed reports that detail billed and expected claim amounts.		**2**					
F-42	**42.183**	The system shall be able to produce reports of patients and customers with credit balances.		**2**					
F-42	**42.184**	The system shall be able to print/preview detailed accounts receivable reports based on types of insurance carriers.		**2**					
F-42	**42.185**	The system shall be able to review patient payment histories and Medicare confirmations and rejections.		**2**					
F-42	**42.186**	The system shall be able to Create Overdue Payment Notes per aging report time period in client statements.		**2**					
F-42	**42.187**	The system shall be able to track amounts charged, expected payment, amount paid, adjusted, or refunded, and any balance due.		**2**					
F-42	**42.188**	The system shall provide a report for work unpaid visits, overpaid visits, and/or NSF payments.		**2**					

F-42	42.189	The system shall be able to view visit and payment history by either client or guarantor.		2					
F-42	42.190	The system shall be able to view summary of all outstanding receivables and “drill down” to review line item details such as payments and adjustments.		2					
F-42	42.191	The system shall be able to use flexible parameters available for moving unpaid visits into collections.		2					
F-42	42.192	The system shall be able to track contract dates.		2					
F-42	42.193	The system shall be able to input collections notes; generate collections notes.		2					
F-42	42.194	The system shall be able to group insurance carriers for collections purposes.		2					
F-42	42.195	The system shall be able to automate collections letters.		2					
F-42	42.196	The system shall be able to prevent billing/claiming until related notes are finalized.	Copied from Manage Clinical Documents: 8.026	2					
F-42	42.197	The system shall provide client service/treatment payor billing based on clinical service/treatment note entry.	Copied from Manage Clinical Documents: 8.060. This approach is in contrast to billing caused by client service/treatment data entry procedures which are performed separate from clinical service/treatment note entry.	2					
F-42	42.198	The system shall prevent inappropriate duplicative claiming of service/treatment rendered.	Moved from Service/Treatment Management: 30.017.	2					
F-42	42.199	The system shall prevent any Medi-Cal claiming for service/treatments rendered while client is located in an Institution for the Mentally Diseased (IMD).	Moved from Service/Treatment Management: 30.018.	2					
F-42	42.200	The system shall prevent billing Medi-Cal for board & care costs of an Psychiatric Health Facility (PHF).	Moved from Service/Treatment Management: 30.019.	2					
F-42	42.201	The system shall have user-friendly routines for updating service/treatment charge rates.	Moved from Service/Treatment Management: 30.020.	2					
F-42	42.202	The system shall allow payor source to be determined by both service/treatment type.	Moved from Service/Treatment Management: 30.024.	2					
F-42	42.203	The system shall allow payor source to be determined by service/treatment program.	Moved from Service/Treatment Management: 30.025.	2					
F-42	42.204	The system shall be able to associate a service/treatment with a funding source governed by effective start / end boundaries.	Moved from Service/Treatment Management: 30.026. Examples are: 1) AB3632 IEP service/treatments; 2) Grant funding timeline restrictions; 3) Insurance company or another county authorization period boundary dates;	2					

F-42	42.205	Payment Posting: The system shall provide the ability to post a client's co-pay at time of check-in		2					
F-42	42.206	Payment Posting: The system shall provide automated EOB posting for multiple patients from individual payers		2					
F-42	42.207	Payment Posting: The system shall provide the ability to post insurance payments for multiple patients via batch posting where the software counts down the dollar amount of the check as payments and adjustments are posted to each patient's account.		2					
F-42	42.208	Payment Posting: The system shall provide automatice insurance adjustments for electronic EOB transactions.		2					
F-42	42.209	Payment Posting: The system shall be able to identify when the insurance plan is not paying the appropriate pre-approved amount.		2					
F-42	42.210	Payment Posting: The system shall provide a report showing under payments based on the plan's specific providers' contract.		2					
F-42	42.211	Payment Posting: The system shall provide the ability to post patient payments via a secure internet connection.		2					
F-42	42.212	Payment Posting: The system shall provide the ability to post patient payments via a secure internet connection.		2					
F-43	43.001	The system shall support provider ability to account for all daily staff time including indirect service/treatments which are service/treatments not attributable to a specific client.	The nature of such service/treatments is configurable by the system administrator. They may include education, prevention and various community service/treatments for persons who have not been registered as clients. A variety of over-head activities including administration, supervision, training, QI, record keeping and other activities may be tracked by staff person.	2					
F-43	43.002	The system shall have system administrator capacity to create a variety of critical incident types that can be easily entered and retrieved.	Follow-up responsibility and other configurable fields allow local policy for incident reporting to be supported by this system feature.	2					
F-43	43.004	The system shall provide users an on-line personal task list.	The online personal task list shall include items linked to varied sources like: client appointments for the day; staff meetings; QI reminders on record problems; triggered alerts based on local policy and procedures (e.g. time to renew a service/treatment plan). The personal task list may be interfaced with products such as Outlook and Lotus Notes.	2					

F-43	**43.005**	The system shall include the ability to load, search and retrieve documentation related to local policies and procedures.	These policies and procedures can be linked to the related data screen entry screens. All policy and procedure information can be edited and managed using Microsoft standard text processing capabilities.	**2**					
F-43	**43.006**	The system shall support the development of user-defined screens for gathering data related to the quality management process. This includes user-defined customer satisfaction surveys, customer complaint and compliment forms, provider satisfaction surveys, etc.	Examples are CA DMH POQI's and CA MHSA DCR	**2**					
F-43	**43.007**	The system shall efficiently support integration with systems that can be used to generate generally accepted accounting standards (GAAP)-compliant, double-entry uploads of billing and claims transactions into the county's general ledger and accounts payable systems.		**2**					
F-43	**43.008**	The system shall support data entry alternative interfaces for items such as encounter forms, customer satisfaction surveys, and performance outcome instruments. Methods include scanning, optical character recognition, and intelligent character recognition.		**2**					
F-43	**43.009**	The system shall support the automation of business procedures or "workflows" for which documents, information or tasks are passed from one participant to another in a way that is governed by pre-defined rules or procedures. The system provides the user with guidance as to the various screens required to perform standard procedures.	For example, an admission may require several steps including multiple screens. Omission of key steps will prompt guidance from the system.	**2**					
F-43	**43.010**	The system shall support workflow advisories customized to reflect processes appropriate for particular target groups and organizations.	Examples are: 1) Client registration process queues up client to complete process for required Medi-Cal Share of Cost payments necessary prior to service/treatment being provided; 2) Client registration process broadcasts instant urgent message for clinical support needed in clerical support environment; 3) Billing staff informed that a client has not followed up with payment action as agreed upon; 4) A clinician is notified professional license expires in 60 days.	**2**					

F-43	**43.011**	The system shall support workflow advisory interfaces with standard e-mail systems.	Examples are: 1) E-mail automatically sent to client case coordinator that care plan is due; 2) E-mail automatically sent to appropriate oversight supervisor of an action that has not been completed.	**2**					
F-43	**43.012**	The system shall support workflow advisories that are generated once or repeatedly depending on local business rules.		**2**					
F-43	**43.014**	The system shall support efficient workflows in a Call Logging system.		**2**					
F-43	**43.015**	The system shall support efficient workflows in a Pre-Registration system.	Supports user-defined online pre-registration forms to gather initial client demographic and financial resources information for individuals requesting service/treatment. If the client becomes registered for service/treatment this information can be forwarded to Registration so that duplicate data entry is not required. If the client is already registered as a client in the system this shall be flagged	**2**					
F-43	**43.016**	The system shall support efficient workflows in an Intake Screening system.	Supports user-defined online client screening forms to assist in the determination of whether the client requires service/treatments from the crisis system, hospitalization, referral for outpatient service/treatments, or referral to other community resources. Includes access needs information, presenting problems and other relevant clinical information.	**2**					

F-43	**43.017**	The system shall support efficient workflows in a Referral Management system.	Supports detailed provider profile information for clinicians working at county clinics, independent providers in the provider network, and at contracted provider organizations. Clients can be matched to clinicians based on multiple variables in the Provider Registration Database. This includes information about provider location, specialties, non-English language capability, etc.	**2**					
F-43	**43.018**	The system shall support the issuance and tracking of service/treatment referrals by counties to members of their internal and external provider networks, which are compliant with the ASC X12N 278 - Referral Certification and Authorization format.		**2**					
F-43	**43.019**	The system shall allow users to customize the referral management screens, including the sort and selection criteria, as well as referral letters that can be sent to clients and providers.		**2**					
F-43	**43.020**	The system shall be able to upload information electronically to the Provider Registration Database.	This component is closely linked to the Authorization Management system, that handles when a referral is made and the county is responsible for payment of the service/treatments associated with that referral.	**2**					
F-43	**43.021**	The system shall support efficient workflows in accessing community resource databases.	Allows for the uploading or manual entry of community resources into a searchable database that can be filtered based on user criteria. Counties shall have the option of storing these entries in the provider referral database in ways that keep these records separate from the listing of network providers, or in a separate table that has the same lookup and tracking capacities of the provider referral database.	**2**					

F-43	**43.022**	The system shall support efficient workflows in a Wait List Management system.	Supports the ability to enter prospective clients on a wait list if space is not available for them at a provider that can meet their clinical needs. All wait listed clients will be entered into a user-defined online form that gathers information such as date of entry, referral type, reason for wait list, priority, expected appointment date, etc. Information on the wait list screen can be updated as additional data is gathered or client circumstances change.	**2**					
F-43	**43.023**	The system shall support tracking and sorting prospective clients by priority to assist in moving individual into service/treatment in the proper order.		**2**					
F-43	**43.024**	The system shall generates Request for service/treatment logs, which are available to the state and show the status of clients on the wait list at a given point in time.		**2**					
F-43	**43.025**	The system shall support efficient workflows in a Grievance and Complaints system.		**2**					
F-43	**43.026**	The system shall support client admission and discharge from organizational providers through a user-defined online admission/discharge form, which can be customized for different types of provider organizations.		**2**					
F-43	**43.027**	The system shall support efficient transfer of client information during client transfer from one organizational provider to another.		**2**					
F-43	**43.028**	The system shall support efficient workflows between California Mental Health data systems and California Alcohol and Drug data systems.	This is intended to support seamless county operations of clients that have MH diagnoses, A&D diagnoses, or both.	**2**					
F-43	**43.029**	The system shall support flagging episodes for closing due to service/treatment inactivity.		**2**					
F-43	**43.030**	The system shall support workflows that allow for the efficient coordination of system functions required for processing of clients who are opened and closed on the same day.	Examples of system functions that require special attention for efficient workflow management are episodic and service/treatment functions.	**2**					
F-43	**43.031**	The system shall support the tracking of clients by unit, room and bed, and midnight bed checks for 24 hour client service/treatments; this system can be used to generate daily room charges. This component tracks facility capacity and documents bed availability.		**2**					

F-43	43.032	The system shall support the tracking of dietary requirements for each 24 hour patient by unit, room and bed and creates dietary orders for the kitchen based on the dietary orders.		2					
F-43	43.033	The system shall support the recording and tracking of client valuables that are held on each unit of an inpatient or residential facility.		2					
F-43	43.034	The system shall support scanning key documents and organizing them into a logical structure that allow providers to easily view these documents. These scanned documents shall be able to cross-reference to paper charts.	Intended to cover internal document scanning as well as external document scanning found in "Capture external clinical documents" requirement category above.	2					
F-43	43.035	The system shall support single sign-on software products, while maintaining internal security controls.		2					
F-43	43.037	The system shall be able to auto-populate user defined data fields with patient demographics.		2					
F-43	43.052	The system shall manage business rules for decision support, diagnostic support, workflow control, access privilege, and other local business rules.		2					
F-43	43.053	The system shall manage business rules with create, import, access, update, local customization, inactivation, obsolescence, and audit trail management capacity.		2					
F-43	43.054	The system shall provide business rules audit trails.		2					
F-43	43.055	The system shall use workflow-related business rules to direct the flow of work assignments.		2					
F-43	43.056	The system shall create and manage workflow (task list) queues.	May be thru system interfaces.	2					
F-43	43.057	The system shall create and manage human resources workflow queues.	May be thru system interfaces.	2					
F-43	43.058	The system shall be capable of electronically distributing information to and from internal and external parties.		2					
F-43	43.059	The system shall be able to route notifications and tasks based on system triggers.		2					
F-43	43.060	The system shall dynamically escalate workflow according to business rules.		2					
F-43	43.061	The system shall dynamically redirect workflow according to business rules.		2					
F-43	43.062	The system shall dynamically reassign workflow according to business rules.		2					

F-43	**43.063**	The system shall be able to retrieve and display client encounter data by various user-defined parameters	Examples include: Data entry date, encounter, date, client identifier, encounter type, client provider identifier, diagnosis, referred provider, client care funding, and client financial liability.	**2**					
F-43	**43.064**	The system shall allow users to customize the presentation and data included in all system generated client and staff alerts.		**2**					
F-43	**43.065**	The system shall be able to print all alerts on demand.		**2**					
F-43	**43.066**	The system shall be able to forward an alert to specific provider(s) or other authorized users via secure electronic mail or by other means of secure electronic communication.		**2**					
F-43	**43.087**	Automated Process Flow: The system shall prompt staff for the information that should be gathered during a specific process. For example, when checking in a Medicare Patient, have the patient complete and sign selected forms		**2**					
F-43	**43.088**	Automated Process Flow: The system shall create the required forms on a tablet so that the patient can sign all required forms without the need to print the paper.		**2**					
F-43	**43.089**	Automated Process Flow: The system shall create the required forms on a tablet so that the patient can sign all required forms without the need to print the paper.		**2**					

Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements	**g**	
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-03	3.001	The system shall be able to display current multi-axial diagnoses associated with a client.	We assume current and active to mean the same thing.	3		H			
F-03	3.002	The system shall be able to maintain a history of all diagnoses associated with a client.	This means both current and inactive and/or resolved problems. These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once.	3		H			
F-03	3.003	The system shall be able to maintain the onset date of the diagnoses.	It is a vendor design decision whether to require complete date or free text of approximate date.	3		H			
F-03	3.004	The system shall be able to record the chronicity (chronic, acute/self-limiting, etc.) of a diagnoses.		3		H			
F-03	3.005	The system shall be able to record the user ID and date of all updates to the diagnoses.		3		H			
F-03	3.006	The system shall be able to associate orders, medications, and notes with one or more diagnoses.	One shall be able to identify all visits for a particular diagnosis/problem. . Association can be made in structured data or in non-structured data.	3		H	H		
F-03	3.007	The system shall be able to associate orders, medications and notes with one or more diagnoses; association to be structured, codified data.		3					
F-03	3.008	The system shall be able to maintain a coded list of diagnoses.	For example: ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IV. The Functionality WG will not specify which code set(s) are to be employed.	3		H			
F-03	3.009	The system shall be able to validate that the coded diagnosis is valid for the axis in which its entered.		3					

F-03	3.010	The system shall provide links to the diagnosis validation tables and shall be able to locally manage the table.	Provide categorization by Axis. To assist clinician in accurate documentation display diagnosis code and name upon diagnosis code entry to EHR system.	3					
F-03	3.011	The system shall be able to display inactive and/or resolved diagnoses.		3		X			
F-03	3.012	The system shall be able to separately display active diagnoses from inactive/resolved diagnoses.		3					
F-03	3.013	The system shall accepts either DSM IV or ICD-9 diagnoses as determined by the system administrator.		3					
F-03	3.014	The system shall support cross-walk tables to translate the diagnoses from one classification scheme to another.		3					
F-03	3.015	The system shall track multiple diagnoses based on user-defined criteria, such as admission diagnosis and discharge diagnosis.		3					
F-04	4.001	The system shall be able to create and maintain medication lists.	The medication list shall be "client-centric" and shall include medications prescribed by any provider.	3		H			
F-04	4.002	The system shall be able to expressly indicate that the medication list has been reviewed by both the provider and client; this shall be a structured field.		3					
F-04	4.003	The system shall be able to record prescribed medications information including the identity of the prescriber.		3		H			
F-04	4.004	The system shall be able to maintain medication ordering dates		3		H			
F-04	4.005	The system shall be able to record lab results, future lab types and lab work required for medication monitoring .	Copied to Manage Results: 14.019	3					
F-04	4.006	The system shall be able to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.		3		H			
F-04	4.007	The system shall be able to display medication history for the client. Minimum requirements are: Type, frequency, effective start date and end date, and dosage.	For clarification, medication history includes all medications prescribed since the EMR was established.	3		H			

F-04	**4.008**	The system shall be able to capture medications entered by authorized users other than the prescriber.	It is important to have all current medications in the system for drug interaction checking. This in the future would include the incorporation of medication history obtained from external electronic interfaces, e.g., from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation.	**3**		H			
F-04	**4.010**	The system shall be able to store the following information about medications: start/stop dates, prescriber, date/time last taken, side effects.		**3**					
F-04	**4.011**	The system shall be able to enter non-prescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	This is important for interaction checking, associating symptoms with supplements e.g. the L-trytophan related eosinophila-myalgia syndrome.	**3**		H			
F-04	**4.012**	The system shall be able to record the source of medication information by client report (non verify).		**3**					
F-04	**4.013**	The system shall be able to exclude a medication from the current medication list (e.g., marked inactive, erroneous, completed, discontinued) and document reason for such action and the clinical authority authorizing removal of the medication from the medication list.	Reason for removal or discontinuation shall be captured as a discrete data element or as free text. In future this shall be structured.	**3**		H			
F-04	**4.014**	The system shall store medication information in discrete data fields such as dose, route, sig, dispense amount, refills, associated diagnoses, etc.	Only approved abbreviations shall be included.	**3**		M	L	M	H
F-04	**4.015**	The system shall be able to print a current medication list.		**3**		H			
F-04	**4.016**	The system shall be able to display current medications only.	Excluding prior medications to make current medications easier to identify. Any given medication shall display only once in the list.	**3**		H			
F-04	**4.017**	The system shall include standard medication codes associated with each medication in the list.	It is anticipated that upcoming eRx regulation and the work of AHIC will define these in the near future. This requires publication by HITSP of an implementation guide by 3/07. This requirement will be postponed for a year after the publication of such a guide if one is not available by 3/07.	**3**		H	H		

F-04	4.018	The system shall be able to enter uncoded or free text medications when medications are not on the vendor-provided medication database or information is insufficient to completely identify the medication.	Medications that are not on the vendor provided medication database or not enough information is available to completely identify the medication. This could be either uncoded (Synthroid unknown dose) or free text (blue hypertension pill).	3			H		
F-04	4.020	The system shall be able to enter or further specify in a discrete field that the client takes no medications, date ranges and the reason.		3			H		
F-04	4.021	The system shall be able to enter the source of medication history.	For example, By client report.	3					
F-04	4.022	The system shall be able to record the date of changes made to a client's medication list and the identity of the user who made the changes.	This information may appear as an optional view rather than a required view on the main screen. Need to capture the identity of the user and the date of changes made. Changes are to be recorded at the level of the individual medication.	3			M	H	
F-04	4.023	The system shall support the entry and viewing, on a single screen,of information about medications prescribed by the county, those being taken but prescribed by another provider, drug allergies, and past adverse reactions to particular medications.		3					
F-04	4.024	The system shall make Information readily available about medications that have been tried and considered ineffective and medications that are no longer being taken due to other reasons.		3					
F-04	4.025	The system shall support Tickler Engine reminder rules that estimate and flag when a client's prescribed medication might be running out.		3					
F-04	4.026	The system shall support the review and maintenance of a locally defined formulary and will display drugs determined to be 'first-choice' as defined by the medical administrator.		3					
F-04	4.027	The system shall allow for alternate formularies defined by local site to address special regulatory and county requirements.		3					
F-04	4.028	The system shall include access to the national Drug Classification (NDC) database.		3					
F-04	4.029	The system shall store common prescriptions for quick entry, with each provider having his/her most commonly prescribed medications displayed.		3					
F-04	4.030	The system shall support multiple drug formularies and prescribing guidelines.		3					

F-04	4.031	The system shall be able to update the progress note with prescription information.		3					
F-04	4.032	The system shall allow the provider to document the effectiveness or ineffectiveness of a medication.		3					
F-04	4.033	The system shall store refill and repeat prescription information.		3					
F-04	4.034	The system shall store prescription data for retrieval by any of the following: Drug name, Drug code number (NDC), Amount prescribed, and Schedule.		3					
F-04	4.035	The system shall provide the following drug/prescription order information: drug contraindication, active problem interaction, and appropriate results obtained.		3					
F-04	4.037	The system shall prompt for the client's involvement in an indigent drug payment program, and shall provide a reminder when the application renewal is due.		3					
F-04	4.038	The system shall be able to electronically print prescriptions.	Separated into 2 reqs: 4.038 and 11.017	3					
F-05	5.001	The system shall be able to capture and store lists of medications and other agents to which the client has had an allergic or other adverse reaction. The list shall contain the ability to reference source who states the allergic reaction.	~~The user determines what defines an allergy or adverse reaction.~~	3		H			
F-05	5.002	The system shall be able to specify the type and severity of allergic or adverse reaction.	Allergy type shall be specified as a discrete data element and/or as a free text description. This shall be a modifiable field.	3			H		
F-05	5.003	The system shall be able to specify the type of allergic or adverse reaction in a discrete data field.	Data does not need to be codified.	3					
F-05	5.004	The system shall be able to deactivate an item from the allergy and adverse reaction list.	This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely. The user ID, date & time will be recorded per Security requirements.	3		H			

F-05	**5.005**	The system shall be able to specify the reason for deactivating an allergy/allergen from the allergy list.	Reason for deactivating an allergy type shall be specified as a discrete data element or in non-structured data. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.	**3**			L	M	H
F-05	**5.006**	The system shall be able to record the deactivation of items from the allergy list and clinical authority authorizing removal of the allergy from the allergy list.	Necessary for medico-legal purposes. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.	**3**		M	H		
F-05	**5.007**	The system shall be able to record the identity of the user who added, modified, inactivated or removed items from the allergy list, including attributes of the changed items with associated date stamps.	Attributes include the name of the allergen, the date of the change, and the action (added, modified, inactivated or removed).	**3**					
F-05	**5.008**	The system shall be able to display information which has been inactivated or removed from the list as well as details of information that has been modified.	~~Could include changing the type of reaction for a particular allergy - 2009?~~	**3**		L	L	H	
F-05	**5.009**	The system shall explicitly document that the allergy list was reviewed. The user ID and date stamp shall be recorded when the allergies reviewed option is selected.	Medico-legal and regulatory compliance. This requires the user to explicitly select this option documenting that they have reviewed the allergies with the client. Ideally this would be a structured field.	**3**		H	H		
F-05	**5.010**	The system shall explicitly document, in a structured field, that the allergy list was reviewed. The user ID and date stamp shall be recorded when the allergies reviewed option is selected.	Medico-legal and regulatory compliance. (For audit trail).	**3**					
F-05	**5.011**	The system shall be able to explicitly indicate that a client has no known drug allergies.	Medico-legal and regulatory compliance. This is meant to be specific to drug allergies. Expected to be available by 2008.	**3**		H			

F-05	**5.012**	The system shall be able to explicitly indicate that a client has no known non drug allergies.	Expected to be available by 2008.	**3**					
F-05	**5.013**	The system shall be able to explicitly indicate in a discrete field that a client has no known drug allergies.	Expected to be available by 2008.	**3**					
F-05	**5.014**	The system shall be able to explicitly indicate in a discrete field that a client has no known non drug allergies.	Expected to be available by 2009.	**3**					
F-05	**5.015**	The system shall be able to check for potential interactions between a current medication and a newly entered allergy.		**3**		L	L	H	
F-05	**5.016**	The system shall interface with third party databases that support automated drug allergy checking to be performed during the medication prescribing process.		**3**					
F-06	**6.001**	The system shall be able to capture, store, display, and manage client history.	~~Client history shall be from external and/or internal sources, including client PHR.~~ Examples include past service/treatments, diagnoses, procedures, family history and social history and hospitalization.	**3**		H			
F-06	**6.002**	The system shall be able to capture structured data in the client history.	Structure Data versus free-text data is this criteria's intent. This function demonstrates the ability of a system to capture structured data but does not define the required elements of the client history that shall be structured. Discrete data elements allow for searching and/or reporting by the EHR, and for this criterion the data could be free text or codified. Future functions would define the required client history elements that shall be captured discretely as structured data, and where appropriate codified terminologies will be used.	**3**		M	H		
F-06	**6.003**	The system shall be able to update a client history by modifying, adding, removing, or inactivating items from the client history as appropriate.	Requirement not predicated on the capture of structured data.	**3**		H			
F-06	**6.004**	The system shall be able to capture client history as both a presence and absence of conditions, i.e., the specification of the absence of a personal or family history of a specific diagnosis, procedure or health risk behavior.	Requirement not predicated on the capture of structured data.	**3**		H	H		
F-06	**6.007**	The system shall maintain name, date time of all additions and edits to client history.	In the Security requirement. - S5 and S6.	**3**					

F-06	6.008	The system shall provide for the entry of the source of the history.		3					
F-06	6.009	The system shall have the ability to define and track episodes of care for clients based on state and local definitions of episodes.	This includes: 1) Care provided to an individual within a given service/treatment area, by a specific provider, during a given time period; 2) Separate episodes for outpatient service/treatments and inpatient facility during the same time period; 3) Multiple concurrent outpatient episodes.	3					
F-06	6.010	The system shall support efficient retention of, and subsequent access to, post discharge client contact data.	This may include clinical case management, complaint, or grievance follow up or client surveys.	3					
F-06	6.011	The system shall provide viewing by authorized individuals of all clinical information on the history of past diagnoses, service/treatment plans, service/treatments, and medications.	Clinical Reporting	3					
F-06	6.012	The system shall provide clinical history view screens configurable to accommodate the varying needs of clinicians, case managers and clients.	Clinical Reporting	3					
F-06	6.013	The system shall be able to capture the client's immunization history.	Moved from 8.053.	3					
F-07	7.001	The system shall be able to create and display a summary list for each client that includes, at a minimum, the active problem list, current medication list, medication allergies and adverse reactions	Health record summary is at the client level as opposed to at the level of an individual visit or episode of care. Clinical Reporting	3		H			
F-07	7.002	Patient Encounter Documentation: The system shall provide the ability to view summary information regarding the patient's conditions on one customizable screen and California requirements for CSI and DCR.		3					
F-07	7.003	Patient Summary Page Level 1:The system shall provide the ability to review basic information about the patient including all demographics and insurance information		3					
F-07	7.004	Patient Summary Page Level 2: The system shall provide the ability to review prior visit reasons, active medications, active lab results, next appointments, etc.		3					
F-07	7.005	Patient Summary Page Level 3: The system shall provide strong health maintenance alerts, prior vitals, patient messages, chronic diseases and other patient specific information.		3					
F-07	7.006	Patient Summary Page Level 4: The system shall provide the ability to customize the patient summary page based on the unique needs of the physician and/or the practice.		3					
F-07	7.007	Patient Summary Page Level 4: The system shall provide the ability to customize the patient summary page based on the unique needs of the physician and/or the practice.		3					

F-08	**8.001**	The system shall be able to create clinical documentation or notes (henceforth "documentation").		**3**		H			
F-08	**8.002**	The system shall be able to display clinical documentation.		**3**		H			
F-08	**8.003**	The system shall be able to save a note in progress prior to finalizing the note.		**3**		H			
F-08	**8.004**	The system shall be able to record the date and time stamp at the creation of a clinical document and any status change when the document is completed and finalize.		**3**					
F-08	**8.005**	The system shall be able to finalize a note, i.e., change the status of the note from in progress to complete so that any subsequent changes are recorded as such.	Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	**3**		H			

F-08	**8.006**	The system shall be able to record the identity of the user finalizing each note and the date and time of finalization.	Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	**3**		H			
F-08	**8.007**	The system shall be able to cosign a note and record the date and time of signature.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards. ASTM has developed "2003 Updated ASTM Standard Guide for Electronic Authentication of Health Care Information" to address some of these issues.	**3**			H		
F-08	**8.008**	The system shall be able to addend notes that have been finalized.		**3**		H			

F-08	8.009	The system shall be able to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note.	Please see Security requirements.	3					
F-08	8.010	The system shall be able to record and display the identity of the user who addended or corrected a note, as well as other attributes of the addenda or correction, such as the date and time of the change.		3		H			
F-08	8.011	The system shall be able to enter free text notes.		3		H			
F-08	8.012	The system shall be able to filter, search or order notes by the provider who finalized the note.		3		H			
F-08	8.013	The system shall be able to filter, search or order notes by associated diagnosis within a client record.	This is intended to be the coded diagnosis and not free text in the body of a note.	3			M	H	
F-08	8.014	The system shall be able to capture client vital signs, including blood pressure, Temperature, heart rate, respiratory rate, height, and weight, as discrete data and the physical pain level.	It is understood that vendors shall support conversion to numeric values that can be graphed. Coding in ICD-9 CM, ICD-10 CM, SNOMED, UMLS, etc., would enhance interoperability and for public health surveillance or clinical research.	3		H			
F-08	8.015	The system shall be able to graph height and weight over time.	Moved up from CA-F92, F93, F94	3					
F-08	8.016	The system shall be able to calculate and graph body mass index (BMI) over time.		3					
F-08	8.017	The system shall be able to compare body mass index (BMI) to standard norms for age and sex over time.		3					
F-08	8.018	The system shall be capable of indicating to the user when a vital sign measurement falls outside a preset normal range. Authorized users shall set the normal ranges.		3					
F-08	8.019	The system shall be able to associate standard codes with discrete data elements in a note.	We need to add this to the glossary. Examples include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.	3		H	L	M	H

F-08	**8.020**	The system shall provide templates for inputting data in a structured format as part of clinical documentation. This shall include structured progress notes and intake assessments such as the mini mental health exam.	Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9 CM, ICD-10 CM, SNOMED-CT, and CPT-4.	**3**		H			
F-08	**8.021**	The system shall be able to customize clinical templates.	Customizations shall be site specific.	**3**		H			
F-08	**8.022**	The system shall provide templates for displaying summary data in a structured format.	Examples might include the CDR or the CDA. This requirement does not specify a particular format although many vendors will choose to use the harmonized CCR/CDA/CRS once available.	**3**		H	M	H	
F-08	**8.023**	The system shall be capable of recording comments by the client or the client's representative regarding the accuracy or veracity of information in the client record (henceforth 'client annotations'). This includes external documentation incorporated in the client records.	For 2007 it is sufficient for these to be recorded as either free-text notes (see item F59) or scanned paper documents (see item F86). It is not required that the system facilitate direct entry into the system by the client or client's representative.	**3**					
F-08	**8.024**	The system shall display client annotations in a manner which distinguishes them from other content in the system.	Examples include but are not limited to use of a different font or text color, a text label on the screen indicating that the comments are from a client or client's representative, etc. "Distinguishable" refers specifically to comments made by the client or client's representative, but does not refer to the individual components of that chart that they may disagree with.	**3**					
F-08	**8.025**	The system shall be able to identify and maintain client or client proxy completed clinical information.	Once verified by a physician and shared with other parts of the chart, the shared data does not need to be identified as client completed in all sections where data may be shared, but the original client completed information shall be maintained.	**3**			M	H	

F-08	8.026	The system shall be able to prevent billing/claiming until related notes are finalized.	Copied to 42.196: Administrative A/R. Kept here to review again to see if there is a requirement relative to managing clinical data such as reminding the users to finalize their notes.	3					
F-08	8.027	The system shall be able to document group therapy per California DMH guidelines.	review again	3					
F-08	8.028	The system shall provide a core summary for group therapy notes that can be included in the records of all group participants, with the ability to add client-specific information to a participant's record.		3					
F-08	8.029	They system shall be able to capture documentation and travel time.	review again	3					
F-08	8.030	The system shall allow clinical documentation utilizing a combination of system defaults, provider defined and customized templates.		3					
F-08	8.031	The system shall support automatic service/treatment transactions linked to a progress note entered and signed by a clinician.		3					
F-08	8.032	The system shall support progress notes "pended" by a clinician or by a clinical reviewer to be held and not forwarded to the billing system. This automatic generation feature support "switched" on or off by the system administrator. The system administrator shall be able to enable or disable feature for particular organizational providers or particular clinical staff.		3					
F-08	8.033	The system shall document clinical episodic data per state and local guidelines		3					
F-08	8.034	The system shall document client care assessments per state and local guidelines		3					
F-08	8.035	The system shall offer various standard intake assessment instruments including optional 3rd party licensed assessment tools.		3					
F-08	8.036	The system shall supports the creation of user defined intake assessment forms.		3					
F-08	8.037	The system shall capture progress notes for individuals as well as groups.		3					
F-08	8.038	The system shall provide free form clinical note text entry using standard word processing functions which include spell checking.		3					
F-08	8.039	The system shall ensure notes are easily accessible as part of an integration with the service/treatment entry process.		3					

F-08	8.040	The system shall have the option to generate service/treatment transactions as part of the progress note entry.		3					
F-08	8.041	The system shall allow that while writing a progress note, clinicians have ready access to the current authorization information as well as the service/treatment plan.		3					
F-08	8.042	The system shall provide that each progress note can be linked with key elements of the service/treatment plan as required by regulatory guidelines.		3					
F-08	8.043	The system shall allow administrators to integrate with clinical documents and notes program specific fields for local data requirements.		3					
F-08	8.044	The system shall provide a location check log that supports the tracking of patients by location on a user-defined basis (e.g. every 5 or 10 minutes). This component is used primarily at inpatient facilities.		3					
F-08	8.045	The system shall support electronic signatures of clinical documentation.		3					
F-08	8.046	The system shall support a process whereby a clinical document can be saved but not completed, and completed, signed and finalized. Finalized clinical documents can be appended under separate signature. All steps in the clinical documentation process are date and time stamped. Signed documentation shall not be modified, in keeping with medical record standards. The system is flexible enough to support emerging electronic signature technologies.		3					
F-08	8.047	The system shall be able to merge client health record data if a client has more than one identical type data record opened erroneously.	Does not have to be only duplicate data found in both records.	3					
F-08	8.048	The system shall be able to display and review all data in two similar type client health record records for the same client, highlighting the data that is different.	This will support determining the correct client health record information that should exist subsequent to merging two records to one.	3					
F-08	8.049	The system shall require user confirmation prior to merging any client health record information.		3					
F-08	8.050	If two client health record records are erroneously merged, the system shall provide a mechanism for recreating them as separate records.		3					
F-08	8.051	The system shall be able to define and display specialized questions based on: Client's gender, age and presenting problem.		3					
F-08	8.052	The system shall be able to capture and store risk factors for all new clients.		3					

F-08	8.054	The system shall be able to collect and store the client's family medical history.		3					
F-08	8.055	The system shall require that the progress note be electronically signed upon its completion.	Electronic Signature	3					
F-08	8.056	The system shall trigger a reminder to staff for all progress notes that have not been signed.		3					
F-08	8.057	The system shall include a progress note and mental status evaluation template that is problem oriented and can, at the user's option, be linked to a problem on the service/treatment plan.		3					
F-08	8.058	The system shall support clinical access to a medical terminology dictionary.		3					
F-08	8.059	The system shall be able to create a heading for progress notes which include: Client identification number, client name, date of service/treatment, time of day service/treatment was rendered, duration of service/treatment, type of service/treatment, and provider identifier.		3					
F-08	8.060	The system shall provide client service/treatment payor billing based on clinical service/treatment note entry.	This approach is in contrast to billing caused by client service/treatment data entry procedures which are performed separate from clinical service/treatment note entry. Copied to Administrative A/R: 42.197 as well	3					
F-08	8.061	The system shall provide service/treatment templates that integrate to clinical documentation for client service/treatments.	Templates assist clinical staff in correct service/treatment entry.	3					
F-08	8.062	The system shall allow the ability to enter group progress notes .	Moved from Capture External Clinical Documents: 9.012.	3					
F-08	8.063	The system shall not require the user to enter group progress notes for every client. Clinical documentation relevant to all group attendees shall only be entered once. The system shall allow display of a specific client's progress notes.	Moved from 9.013.	3					
F-08	8.064	Dictation: The system shall provide base line dictation where the physician can dictate a report, electronically send the report to the transcriber and, after completion, the report can be imported back into the patient's EHR folder.		3					
F-08	8.065	Dictation: The system shall provide advanced dictation where data is automatically captured from within the EHR and the physician's only needs to dictate specific findings within a specific section of the patient's note. The transcriber receives an electronic wave file, and after transcription, the typed data is automatically imported back into the section of the note.		3					

F-08	8.066	Dictation: The system shall provide advanced dictation with the capability of voice-to-text dictation designed to eliminate 90% of all transcription costs.		3					
F-08	8.067	Dictation: The system shall provide advanced, nationally recognized, practice customized voice to text dictation based on practice specific requirements and clinical guidelines based on the patient's clinical condition.		3					
F-08	8.068	Dictation: The system shall provide advanced, nationally recognized, practice customized voice to text dictation based on practice specific requirements and clinical guidelines based on the patient's clinical condition.		3					
F-08	8.069	Behavioral Information: The system shall provide full, interactive, mental/behavioral health templates.		3					
F-08	8.070	Behavioral Information: The system shall provide nationally recognized mental/behavioral health care plans and alerts designed to improve the capture of patient related information based on best practices.		3					
F-08	8.071	Behavioral and Medical Information: The system shall provide the ability to share clinical information gathered during a medical visit including: clinical alerts, active medications, lab results, diagnostic codes, allergies, a history of the present illness, and a review of the client's symptoms.		3					
F-08	8.072	Behavioral and Medical Information: The system shall provide functionality for both mental/behavioral health and medical conditions all within one database following organization-specific security rules based on best practices.		3					
F-08	8.073	Behavioral and Medical Information: The system shall provide functionality for both mental/behavioral health and medical conditions all within one database following organization-specific security rules based on best practices.		3					
F-09	9.001	The system shall be able to capture and store external documents.	Scanned documents are sufficient in 2005, granular data will be expected in the future. This covers all types of documents received by the practice that would typically be incorporated into a health record, including but not limited to faxes, referral authorizations, consultant reports, and client correspondence of a clinical nature.	3		H			
F-09	9.003	The system shall be able to save scanned documents as images.		3		H			
F-09	9.004	The system shall be able to receive, store in the client's record, and display text-based external reports.	This could be either from an external system or from scanning with optical character recognition. Integration here means the ability to find and display the documents within the system.	3		H			

F-09	9.005	The system shall be able to index and retrieve scanned documents based on such indexes as the document type, the date of the original document, the date of scanning, subject and title.		3					
F-09	9.006	The system shall provide access to clinical images. They shall be accessible from within the client's chart and labeled and date-time stamped or included in a client service/treatment document. These images shall be stored within the system or be provided through direct linkage to external sources.	These images may include but are not limited to radiographic, digital or graphical images. Eventually the goal would be to allow linkage to external systems such as a hospital PAC system.	3			L	M	H
F-09	9.008	The system shall be able to accept, store in the client's record, and display medication details from an external source.	External source may include a retail pharmacy, the client, or another provider. Medication details include strength and sig. Does not imply that this date will populate the medication module; that functionality will be required in future. Year to be determined based on applicability of available standards.	3		L	L	H	
F-09	9.009	The system shall be able to accept, store in the client's record, and display structured text-based reports received from an external source.	This allows for more granular integration of data.	3		M	H		
F-09	9.010	The system shall be able to accept, store in the client's record, and display, codified data received from an external source.	Such as those sent from another physician using a standardized format. Coding schema will be determined by HITSP and will be included in test scenarios in appropriate years.	3		L	L	H	
F-09	9.011	The system shall provide ability to store the source of documents from an external source.		3					
F-09	9.012	Document Image Management: The system shall provide the ability to scan in new documents at the front and back desk with workflow guidelines for routing documents for signature or review.		3					
F-09	9.013	Document Image Management: The system shall provide nationally recognized, practice customized document imaging that is designed to capture both clinical and financial data regarding the patient, which can be used by both the clinical staff and the financial/billing staff.		3					
F-09	9.014	Document Image Management: The system shall provide the ability to create specific files for scanning of staff information, invoices, and other documents specific to the practice, but not oriented towards a given patient.		3					
F-09	9.015	Document Image Management: The system shall provide the ability to create specific files for scanning of staff information, invoices, and other documents specific to the practice, but not oriented towards a given patient.		3					

F-10	**10.001**	The system shall provide access to client instructions and client educational materials, which shall reside within the system or be provided through links to external sources.	An example would be a vaccine information statement.	**3**		H	H		
F-10	**10.002**	The system shall provide access to medication instructions, which shall reside within the system or be provided through links to external sources.		**3**		H			
F-10	**10.003**	The system shall provide access to test and procedure instructions that can be customized by the physician or health organization. These instructions shall reside within the system or be provided through links to external sources.	This item relates to customization of instructions, not to recording in client record that instructions have been provided.	**3**		M	H		
F-10	**10.004**	The system shall be able to record that client specific instructions or educational material were provided to the client.	This does not require automatic documentation.	**3**		H			
F-10	**10.005**	The system shall be able to create client specific instructions.		**3**		H			
F-10	**10.006**	The system shall have the capacity to create, import, review, update, or delete client education materials.		**3**					
F-10	**10.007**	The system shall provide printed client education materials in culturally appropriate languages on demand or automatically at the end of the encounter.		**3**					
F-10	**10.008**	The system shall include the ability to develop client instructions for a broad range of service/treatments delivered by providers.		**3**					
F-10	**10.009**	The system shall allow user modification to instructions to suit individual client needs without altering the original content.		**3**					
F-10	**10.010**	The system shall enable the linkage of client instructions to care plans/practice guidelines/orders/ enabling automatic printing.		**3**					
F-10	**10.011**	The system shall allow client instructions to be printed on demand independent of care plans/guidelines/orders.		**3**					
F-10	**10.012**	The system shall support the development of a user-defined online Crisis Management Plan that is generally prepared by the client and their case manager. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client.		**3**					
F-10	**10.013**	The system shall support efficient client advance directives development, and maintenance.		**3**					

F-10	10.014	The system shall support integration of client advance directives with other system functions. This includes linkages to standard care plans, guidelines, protocols; clinical task assignment and routing; Inter-provider communication; Scheduling; Manage Practitioner/Patient relationships; and Enforcement of Confidentiality.	Examples are: 1) Referrals of client to other provider care would include sharing of advance directives, as appropriate. 2) Medication prescription systems may be limited by advance directives.	3					
F-10	10.015	The system shall support user-defined screens for tracking crisis episode data including date and time of first contact, referral source, clinical notes about the crisis including user-defined checklists and text-based crisis notes that allow for the recording of diagnosis, level of functioning and other relevant clinical data.		3					
F-10	10.016	The system shall support tracking and easy viewing of the service/treatments provided during the crisis episode.		3					
F-10	10.017	Patient Education: The system shall provide educational materials from national companies, which is updated regularly and that can be modified by the practice and printed in multiple languages.		3					
F-10	10.018	Patient Education: Rather than offering a specific patient access to an established (general) source or platform, the system shall couple the diagnosis, treatment decision or condition of the patient with the dedicated specific education information that applies to the actual case.		3					
F-10	10.019	Patient Education: Rather than offering a specific patient access to an established (general) source or platform, the system shall couple the diagnosis, treatment decision or condition of the patient with the dedicated specific education information that applies to the actual case.		3					
F-14	14.001	The system shall be able to indicate normal and abnormal results based on data provided from the original data source.	As each lab has it's own normal values, these shall be reflected in the indication as to whether a lab is normal or abnormal.	3		H			
F-14	14.002	The system shall be able to display numerical results in flow sheets and graphical form in order to compare results, and shall be able to display values graphed over time.	It is desirable for the system indicate if abnormal results are high or low.	3		M	H		
F-14	14.003	The system shall be able to display non-numeric current and historical test results as textual data.		3		H			
F-14	14.005	The system shall be able to filter or sort results by type of test and test date.		3					
F-14	14.006	The system shall be able to filter or sort results by client in areas where results from multiple clients are displayed.		3					
F-14	14.007	The system shall be able to forward a result to other users.		3		M	M	H	

F-14	**14.008**	The system shall be able to link the results to the original order.	In 2007 this link can be effected manually by changing the status of the order from pending to complete. Future requirements could automate this link for certain electronically received labs although the requirement shall not require that all types of orders be electronically linked to the results since the variety of result formats can be quite large (PT consult, Diabetes education...) and even the variety of lab result formats can be wide.	**3**		M	M	H	
F-14	**14.009**	The system shall allow free text comment to a result that can be seen by another user who might subsequently view that result.		**3**		H	H		
F-14	**14.010**	The system shall be able to associate one or more images with a result.	Through direct storage or links to the data.	**3**		M	M	H	
F-14	**14.014**	The system shall provide the ability to enter results directly into the system.		**3**					
F-14	**14.015**	The system shall provide an intuitive, user-customizable result entry screen linked to orders.		**3**					
F-14	**14.016**	The system shall allow authorized users to copy selected results into a note.		**3**					
F-14	**14.017**	The system shall display the following result data: Client name, date/time of order, date/time results were last updated, test or order name, alerts identifying changes/amendments to the test or procedure.		**3**					
F-14	**14.018**	The system will use visual cues to highlight abnormal results.		**3**					
F-14	**14.019**	The system shall be able to record lab results, future lab types and lab work required for medication monitoring .	Copied from Manage Medication List: 4.005	**3**					
F-16	**16.001**	The system shall have the ability to provide access to standard care plan, protocol and guideline documents when requested at the time of the clinical service/treatment. These documents may reside within the system or be provided through links to external sources.	This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance.	**3**		H			

F-16	16.002	The system shall be able to create site-specific care plan, protocol, and guideline documents.	This includes the use of clinical trial protocols to ensure compliance. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.	3		H			
F-16	16.003	The system shall be able to modify site-specific standard care plan, protocol, and guideline documents obtained from internal and external sources.		3		M	H		
F-16	16.004	The system shall trigger an alert for upcoming care plan due dates.		3					
F-16	16.005	The system shall provide a variety of pre-defined assessment forms .	Examples include psycho-social assessments, intake assessments, Addiction Severity Index (ASI), inpatient evaluations, and residential placement evaluations.	3					
F-16	16.006	The system shall provide a forms development tool set designed to allow locally defined assessment forms to be created. Locally defined forms can capture data as defined by the system administrator.	Such forms may also display data collected from “non-clinical” functions (e.g. demographic data, address, current diagnosis).	3					
F-16	16.007	The system shall include an assessment function configurable to generate targeted problems for service/treatment and such problems can flow to the service/treatment planning process.		3					
F-16	16.008	The system shall allow clinicians to build service/treatment plans for various target populations.		3					
F-16	16.009	The system shall support user-configurable data sets which describe key components of service/treatment plans appropriate to specific target populations.		3					
F-16	16.010	The system shall provide immediate clinician access to industry standard clinical libraries of clinical evidence-based practice guidelines.	Access to be available for inquiry during the clinical decision making process including progress notes, service/treatment planning and prescribing. Intended to support clinical diagnosis, problem, goals, objectives and interventions definitions.	3					
F-16	16.011	The system shall allow users to configure views of clinical evidence-based practice guidelines libraries.	These libraries will be definable by user, program and site.	3					
F-16	16.012	The system shall support practice guidelines customizable to respond to various theoretical approaches.		3					
F-16	16.013	The system shall make available current and past clinical authorizations as well as clinical outcome results.		3					

F-16	16.014	The system shall allow definition and/or modification by authorized clinical supervisors of all clinical guideline elements that underlie service/treatment planning .		3					
F-16	16.015	The system shall make printable versions of service/treatment plans available for clients.		3					
F-16	16.016	The system shall supports the process of obtaining client signatures on service/treatment plans.		3					
F-16	16.017	The system shall support the development of client created wellness action plans. Clients may designate users authorized to view such plans. A printable version of the plan is available for clients.	Such plans contain information provided by the client which includes their personal strategy for recovery. The plan may also include crisis contact information, advance medication directions, and advance directives from the consumer.	3					
F-16	16.018	The system shall be able to import/create, review and amend information about the provider's explanation and the client understanding of the recommended and/or alternative care plan, the actions taken to safeguard the client to avert the occurrence of morbidity, trauma, infection, or condition deterioration.		3					
F-16	16.019	The system shall be able to identify and keep key elements of data for each service/treatment episode. Due to multiple locations of service/treatments, it shall be helpful to know at any point in time, which types of service/treatments have been received or are currently being received. Key client –related service/treatment information is obtained at each presentation of a new level of service/treatment.		3					
F-16	16.020	The system shall import information from prior service/treatment plans to minimize date entry, but shall maintain both original and new information as separate service/treatment plans.		3					
F-16	16.021	The system shall have a module for capturing all five axes of DSM-IVR, using problem lists for adults and children for Axis IV and GAF/CGAS scores for Axis V.		3					
F-16	16.022	The system shall provide an easy method of presenting problem lists (i.e., pull down lists), with the ability to add additional issues.		3					
F-16	16.023	The system shall have service/treatment intervention suggestions which are tied to issues selected best practice intervention.		3					
F-16	16.024	Assessment and Treatment Plans: The system shall provide Assessment and Treatment plans based on national best practice guidelines		3					

F-16	**16.025**	Assessment and Treatment Plans: The system shall provide Assessment and Treatment plans based on national best practice guidelines		**3**					
F-17	**17.001**	The system shall be able to record the reason for variation from care plans, guidelines, and protocols as discrete data.		**3**		H	H		
F-19	**19.001**	The system shall document medication administration.		**3**		H			
F-19	**19.002**	The system shall document, for any medication, the medication type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.		**3**					
F-21	**21.001**	The system shall be able to establish criteria for disease management, wellness, and preventive service/treatments based on client demographic data (minimally age and gender).	This includes the use of clinical trial protocols to ensure compliance.	**3**		H			
F-21	**21.002**	The system shall display triggered alerts based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields. It is assumed that when a service/treatment is completed, this change will be immediately reflected with removal of the prompt.	**3**		H			
F-21	**21.003**	The system shall be able to establish criteria for disease management, wellness, and preventive service/treatments based on clinical data (problem list, current medications).	Lab results in future years	**3**		M	H		
F-21	**21.004**	The system shall be able to update disease management guidelines and associated reference material.	This allows the system's decision support tools to support changes in best practice guidelines.	**3**		H			
F-21	**21.005**	The system shall be able to update preventive service/treatments/wellness guidelines and associated reference material.		**3**		H			
F-21	**21.006**	The system shall be able to override guidelines.		**3**		H			
F-21	**21.007**	The system shall be able to document reasons disease management or preventive service/treatments/wellness prompts were overridden.	Needed for medico-legal reasons and clinical decision support.	**3**		M	H		

F-21	**21.008**	The system shall be able to modify the rules or parameters upon which guideline-related alert triggers are based.	This is necessary for modifications as guidelines change or practices wish to adhere to more stringent levels for example, using a HbA1c target of 6.5% instead of 7%.	**3**		L	M	H	
F-21	**21.009**	The system shall trigger clinical "Red Flag" alerts that present urgent clinical information such as danger warnings, suicide watch or similar, drug allergies, history of adverse reactions to specific drugs, and other urgent precautions.		**3**					
F-21	**21.010**	The system shall trigger "Red Flag" alerts to be viewed at various key screens including those that handle progress notes, appointments and service/treatment plans.		**3**					
F-21	**21.011**	The system shall assure triggered "Red Flag" alerts are visible to all authorized users.		**3**					
F-21	**21.012**	The system shall support disease management registered by: Allowing patient tracking and follow up based on user defined diagnoses; integrating all patient information within the system; providing a longitudinal view of the patient medical history; providing access to patient service/treatments and outcomes.		**3**					
F-21	**21.013**	The system shall automatically identify all high-risk patients and notifies clinical staff for preventive care.		**3**					
F-21	**21.014**	The system shall utilize user-authored and/or third party developed clinical guidelines for disease and registry management.		**3**					
F-21	**21.015**	The system shall generate follow-up letters to physicians, consultants, external sources, and clients based on a variety of parameters such as date, time since last event, etc., for the purpose of collecting health data and functional status for the purpose of updating the client's record.		**3**					
F-21	**21.016**	The system shall provide the capability to link all other Disease Management functions to all other sections of the EHR.		**3**					
F-21	**21.018**	Disease Management and Clinical Trials: The system shall provide base line Disease Management and Outcomes Reporting with Clinical Trials reporting.		**3**					
F-21	**21.019**	Disease Management: The system shall provide Disease Management that can be customized by the practice.		**3**					
F-21	**21.020**	Disease Management: The system shall provide nationally recognized, practice customized disease management tracking based on a patient's disease state or condition.		**3**					

F-21	**21.021**	Disease Management: The system shall prompt the user with lists of relevant tests and therapies as well as other relevant symptoms, history questions and physical finding questions that might not have been asked yet.		**3**					
F-21	**21.022**	Disease Management: The system shall prompt the user with lists of relevant tests and therapies as well as other relevant symptoms, history questions and physical finding questions that might not have been asked yet.		**3**					
F-22	**22.001**	The system shall be able to identify preventive service/treatments, tests, or counseling that are due on an individual client.	In the future, the system shall perform this automatically and proactively "contact" client(s) without physician intervention (e.g. automated reminder letter). These guidelines might come from national organizations, medical societies, etc.	**3**		M	H		
F-22	**22.002**	The system shall be able to identify criteria for disease management, preventive, and wellness service/treatments based on clinical data (problem list, current medications, lab values).		**3**		L	L	H	
F-22	**22.003**	The system shall be able to modify guidelines that trigger reminders.		**3**		M	H		
F-22	**22.004**	The system shall be able to notify the provider that clients are due or are overdue for disease management, preventive, or wellness service/treatments.		**3**		M	H		
F-22	**22.005**	The system shall be able to produce a list of clients who are due or are overdue for disease management, preventive, or wellness service/treatments.		**3**		M	H		
F-22	**22.006**	The system shall be able to automatically generate letters to remind the client or the client's guardian of service/treatments that are due.	Reminders that include PHI shall be delivered through HIPAA-compliant means.	**3**		L	L	H	
F-22	**22.007**	The system shall be able to automatically generate an electronic reminder to the client or the client's guardian of service/treatments that are due.	Reminders that include PHI shall be delivered through HIPAA-compliant means.	**3**					
F-22	**22.008**	Disease Management and Clinical Trials: The system shall provide advanced Disease Management and Outcomes Reporting with Clinical Trials reporting that is useable for multiple diseases and problems, provides reminders for health maintenance, prompts visits and screenings protocols, has prompts/alerts that can be modified by clinician, tracks patient visits, tracks patient lab results, flags unfilled orders for labs, prescriptions, etc.		**3**					
F-23	**23.001**	The system shall be able to create and assign tasks by user or user role.	Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.	**3**		H			

F-23	23.002	The system shall be able to present a list of tasks by user or user role.	Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.	3		H	M	H	
F-23	23.003	The system shall be able to re-assign and route tasks from one user to another user.		3		M	M	H	
F-23	23.004	The system shall be able to designate a task as completed.		3		H			
F-23	23.005	The system shall be able to remove a task without completing the task.	Removing a task eliminates it from an individual user's "to do" list, not from audit logs, etc.	3		H			
F-23	23.006	The system shall be able to automatically escalate incomplete tasks to the appropriate supervisor or authority.	Escalation can be based on elapsed time or time of day.	3		L	L	H	
F-24	24.002	The system shall be able to incorporate paper documents from external providers into the client record.		3		H			
F-24	24.006	The system shall be compatible with multiple payment methods for services provided under an authorization including fee for service, case rate, per diem, etc.		3					
F-24	24.007	The system shall support several methods of setting, tracking and providing reminders of service/treatment limits for each type of authorization.	Methods include number of visits or days, number of client or clinician service/treatment hours, number of days or weeks, specific service/treatment codes, service/treatment codes clusters, or specific dollar limits.	3					
F-24	24.008	The system shall be integrated with options for linking specific authorization types to insurance plans to aid in the utilization management of those authorizations. As service/treatment is provided, actual service/treatments shall be comparable with authorized amounts.		3					
F-24	24.009	The system shall have multiple ways of notifying providers and utilization managers of remaining balances and impending authorization expirations, including during data entry, regular reports and tickler systems.		3					
F-24	24.010	The system shall integrate with an authorization system with user-defined rules for determining whether provider payment for unauthorized service/treatments will be pended or paid and whether these service/treatments will be billed to a third party payor.		3					

F-24	24.011	The system shall support electronically processed Notice of Action letters to a provider and client, informing them of service/treatment denial/reduction and informing them of their due process rights.	NOA example: Authorizations are denied because medical necessity has not been met, or if a level of care request is reduced,	3					
F-24	24.012	The system shall have the ability to record and track communications with provider organizations and individual clinicians.	Includes the recording and tracking of notes related to provider requests and complaints as well as contacts initiated by county staff.	3					
F-24	24.013	The system shall include a tickler system for ensuring follow up of outstanding inter-provider communications.		3					
F-24	24.014	The system shall support processes that automatically support referral of potential Medi-Cal indigents to Medi-Cal eligibility determination staff.	Examples include referral letters or direct scheduling with county social services Medi-Cal eligibility workers or Social Security Department workers.	3					
F-24	24.018	Clinician Dashboard: The system shall provide a base line clinician dashboard that shows patients for the day and any messages that are out standing, including patient calls, refill requests, lab orders to review, etc.		3					
F-24	24.019	Clinician Dashboard: The system shall provide a clinician dashboard that can receive and route clinical messages and reports to anyone within the practice.		3					
F-24	24.020	Clinician Dashboard: The system shall provide a clinician dashboard that can track the location of the patient throughout the clinic.		3					
F-24	24.021	Clinician Dashboard: The system shall provide a clinician dashboard that can transmit clinical messages and reports to clinicians outside of the office.		3					
F-24	24.022	Clinician Dashboard: The system shall provide a clinician dashboard that includes practice statistics regarding visits, revenues, and AR days by day, month, and year.		3					
F-24	24.023	Clinician Dashboard: The system shall provide a clinician dashboard that includes practice statistics regarding visits, revenues, and AR days by day, month, and year.		3					
F-24	24.024	Clinical Messages: The system shall provide basic e-messages from and to staff to help eliminate “sticky notes”.		3					
F-24	24.025	Clinical Messages: The system shall provide e-messages from staff including automated routing and tracking of messages.		3					
F-29	29.001	The system shall be able to define one or more reports as the formal health record for disclosure purposes.	This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.	3		M	H		

F-29	**29.002**	The system shall be able to generate hardcopy or electronic output of part or all of the individual client's health record.	This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.	**3**		H			
F-29	**29.003**	The system shall be able to generate hardcopy and electronic output by date and/or date range.		**3**		M	H		
F-29	**29.004**	The system shall be able to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output leaves the actual PHI data unmodified in the original record.	De-identifying data on hardcopy or electronic output is necessary for research. However, it is emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Health record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers;	**3**		L	M	H	H
F-29	**29.005**	The system shall be able to create hardcopy and electronic report summary information (procedures, medications, labs, allergies, and vital signs).	The report that's produced shall be organized by section to make it easier to read.	**3**		M	M	H	
F-29	**29.006**	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	This criterion may be satisfied by providing the ability to create a note in the client's record. More advanced functionality may be market differentiators or requirements in later years.	**3**					

F-29	29.007	The system shall be able to access, or extract, separate health record components to display, report , print, or transfer a complete logical health record when necessary.	This requirement includes health components distributed among different software applications	3					
F-29	29.008	The system shall be able to extract partial or complete health record information for clinical, administrative, financial, research, quality analysis, and public health purposes.	Includes ability to output partial or complete history of client healthcare.	3					
F-30	30.001	The system shall be able to document a client service/treatment.		3		H			
F-30	30.002	The system shall be able to document service/treatments by one or more of the following means: direct keyboard entry of text; structured data entry utilizing templates, forms, pick lists or macro substitution; dictation with subsequent transcription of voice to text, either manually or via voice recognition system.	This does not preclude entry via new technologies.	3		H			
F-30	30.003	The system shall be able to associate individual service/treatments with diagnoses.		3					
F-30	30.004	The system shall have the ability to provide filtered displays of service/treatments based on service/treatment characteristics, including date of service, service/treatment provider and associated diagnosis.		3		H	M	H	
F-30	30.005	The system shall allow service/treatment data entry that accurately supports California billing requirements,	Includes collection of minutes of service/treatment, co-therapist information, and number in group for outpatient service/treatments.	3					
F-30	30.006	The system shall support a variety of data entry methods that are typically performed by non-clinical support staff.	This includes single service/treatment entry screen, usually connected with outpatient and case management service/treatments; multi-client and/or multi-service/treatment log entry; and service/treatment entry for 24-hour programs that allows for the rapid service/treatment recording of a daily census.	3					
F-30	30.007	The system shall have data entry methods designed to allow maximum efficiency for outpatient, day treatment, and 24-hour programs.		3					
F-30	30.009	The system shall provide efficient functionality that allows providers to enter their own service/treatment data.		3					

F-30	30.010	The system shall record the date-time stamp at any creation, void or replacement of a service/treatment record .	Security	3					
F-30	30.011	The system shall record the user who entered, voided or replaced a service/treatment record.	Security	3					
F-30	30.012	The system shall provide efficient support for admission, discharge and recording of service/treatments for a crisis service/treatment.		3					
F-30	30.013	The system shall provide a data entry screen to support the admission, discharge and recording of service/treatments for a crisis service/treatment.	See workflow # 23 for related workflow support across system functions.	3					
F-30	30.014	The system shall immediately perform essential validations as service/treatments are entered in to the system.	Examples of essential validations are: 1)Appropriate provider credentials; 2) service/treatment time start / end or duration is acceptable; 3) Location of service/treatment is appropriate; 4) Multiple service/treatment limits not exceeded; 5) Cost of service/treatment appropriate to authorized amount; 7) service/treatment is allowable by service/treatment funding requirements.	3					
F-30	30.015	The system shall support efficient staff maintenance of service/treatment validation tables to assure compliance with local, State and Federal regulations.		3					
F-34	34.001	The system shall be able to update the clinical content or rules utilized to generate clinical decision support reminders and trigger alerts.	Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.	3		M	H		
F-34	34.002	The system shall be able to update clinical decision support guidelines and associated reference material.	Any method of updating would be acceptable. Content could be third party or customer created.	3		M	H		
F-34	34.003	The system shall be able to initially author and revise clinical practice guidelines.		3					
F-34	34.004	The system shall support linkages between the clinical practice guidelines application and other system modules.		3					
F-34	34.005	The clinical practice guideline module shall be able for rapid documentation of the client's progress through the clinical progress guidelines phases.		3					

F-34	34.006	The system shall provide clinical practice guideline formats that are: Intuitive, easy to use, and user customizable.		3					
F-34	34.007	The system shall support tools to speed up clinical decision support data entry.	Examples are: Pull down menus and check boxes.	3					
F-34	34.008	The system shall support reporting and analysis of any/all components included in the clinical practice guidelines module.		3					
F-34	34.009	The system shall create, review, and update information about performance measures that shall be used to monitor the attainment of objectives, the quantitative and qualitative data to be collected, performance metrics, collection means and origin of data to be evaluated.		3					
F-34	34.010	The system shall allow the provider or other authorized user to override any or all parts of the guideline.		3					
F-34	34.011	Alerts and Clinical Decision Support: The system shall provide advanced alerts and Clinical Decision Support (CDS) based on nationally recognized sources that are updated on a routine basis. The alerts must include: drug alerts, clinical best practices, health maintenance alerts, and disease management guidelines.		3					
F-34	34.011	Evidence-based reference content: The system shall provide advanced, nationally recognized, practice customized clinical reference content with clear labeling of the levels of evidence for facts/assertions and grades of recommendation for recommendations made. These levels and grades are clearly and transparently based on the quality of the underlying evidence using reproducible processes.		3					
F-34	34.012	Alerts and Clinical Decision Support: The system shall provide advanced alerts and Clinical Decision Support (CDS) based on nationally recognized sources that are updated on a routine basis. The alerts must include: drug alerts, clinical best practices, health maintenance alerts, and disease management guidelines.		3					
F-34	34.013	Evidence-based reference content: The system shall provide base line Evidence-based reference content.		3					
F-34	34.014	Evidence-based reference content: The system shall provide advanced Evidence-based reference content by providing links to clinical references which EMR users can then search or browse to find information via nationally recognized Evidence-based medicine.		3					
F-34	34.015	Evidence-based reference content: The system shall provide advanced Evidence-based reference that can be customized to the practice's unique requirements.		3					
F-34	34.016	Evidence-based reference content: The system shall provide advanced, nationally recognized, practice customized clinical reference content with clear labeling of the levels of evidence for facts/assertions and grades of recommendation for recommendations made. These levels and grades are clearly and transparently based on the quality of the underlying evidence using reproducible processes.		3					

F-43	**43.003**	The system shall support critical incident types that are coordinated with triggering administrative alerts.		**3**					
I-05	**5.003**	Clinical Messages: The system shall provide the ability to communicate electronically one–way to the patient via secured email.		**3**					
I-05	**5.004**	Clinical Messages: The system shall provide the ability for 2-way e-messages with the patient.		**3**					
I-05	**5.005**	Clinical Messages: The system shall provide the ability for 2-way e-messages with the patient.		**3**					

Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements		
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DRAFT

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-04	4.009	The system shall be able to capture, store and display medication history received electronically.		4					
F-04	4.039	CPOE eRX: The system shall provide the ability to create customized preference lists based on the clinical findings of the patient		4					
F-06	6.015	CPOE eRX: The system shall be able to display the medication history of client ordered by service provider AND other medical providers outside the clinic.		4					
F-11	11.001	The system shall be able to create prescription or other medication orders with sufficient information for correct filling and administration by a pharmacy.	The term pharmacy here refers to all entities which fill prescriptions and dispense medications including but not limited to retail pharmacies, specialty, and mail order pharmacies.	4		H			
F-11	11.002	The system shall be able to record user and date stamp for prescription related events, such as initial creation, renewal, refills, discontinuation, and cancellation of a prescription.		4		H			
F-11	11.003	The system shall be able to capture the identity of the prescribing provider for all medication orders		4					

F-11	**11.004**	The system shall allow authorized individuals to cosign medication orders.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	**4**			M	H	
F-11	**11.005**	The system shall be able to update newly prescribed prescriptions medications.		**4**		H			
F-11	**11.006**	The system shall have search capacity to provide a list of medications by both generic and brand name.	Related to CA -F137.	**4**		H	H		
F-11	**11.007**	The system shall be able to maintain a coded list of medications.	For clarification - Coding means a unique identifier for each medication. This functional requirement does not intend to require a national system of coding for medications.	**4**		H			
F-11	**11.008**	The system shall be able to capture common content for prescription details including strength, sig, quantity, and refills to be selected by the ordering clinician.	We encourage the development of standard national abbreviations and that only approved abbreviations shall be supported.	**4**		H			
F-11	**11.009**	The system shall be able to check for daily dose outside of recommended range for client age (e.g., off-label dosing).	Year to be determined once e-prescribing sig requirements have been defined.	**4**			L	L	M
F-11	**11.010**	The system shall be able to check for dose ranges based on client age and weight.	Depends on availability of **F119** in the system.	**4**					
F-11	**11.011**	The system shall be able to select a drug by therapeutic class.	As available through 3rd-party drug databases.	**4**		M	M	H	
F-11	**11.012**	The system shall be able to receive, display and store information received through review electronic prescription eligibility.	Will be required by e-prescribing. This criterion shall maintain a record of whether the client was eligible for coverage in the system.	**4**					

F-11	**11.013**	The system shall be able to display and store information received through review of health plan/payer formulary.	If this review included medications already on the medication list, a duplicate record in the medication shall not be created (same date, medication, strength, and prescriber). Formulary checking refers to whether a particular drug is covered.-	**4**		L	L	H	
F-11	**11.014**	The system shall be able to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).		**4**		H			
F-11	**11.015**	The system shall be able to print and electronically fax prescriptions.	Appropriate audits and security shall be in place.	**4**		H			
F-11	**11.016**	The system shall be able to re-print and re-fax prescriptions.	This allows a prescription that did not come out of the printer, or a fax that did not go through, to be resent/reprinted without entering another prescription. Appropriate audits and security shall be in place.	**4**		?			
F-11	**11.017**	The system shall be able to send prescriptions electronically.	See also Category: Pharmacy communication starting with DMH Rq. Ref. CA-F227. Faxing for 2006, tentative electronic 2007 once standards are promulgated. This presupposes that the pharmacy is capable of receiving electronic prescriptions. This function relates to computer e-prescribing and not faxing. Appropriate audits and security shall be in place.	**4**		M	H		
F-11	**11.018**	The system shall be able to display a dose calculator for client-specific dosing based on weight and age.	This allows the user to enter pertinent information to calculate doses. This would be an interim step until databases are available to calculate doses automatically.	**4**		L	L	H	
F-11	**11.019**	The system shall be able to display client specific dosing recommendations based on age and weight.	This would calculate automatically from pertinent information in the chart (age and weight) and shall be in standard units and based on a standard periodicity. This is contingent upon availability of databases. We encourage their rapid development.	**4**		L	L	H	

F-11	11.020	The system shall be able to display client specific dosing recommendations based on renal function.	On roadmap for 2010	4					
F-11	11.021	The system shall have the ability to receive and display information about the client's financial responsibility for the prescription.	This could include co-payments or tier level of the drug obtained through an interface with a pharmacy benefits manager (PBM).	4		L	L	H	
F-11	11.022	The system shall be able to identify medication samples dispensed, including lot number and expiration date.	Lot numbers and expiration date could be entered in free text or encoded.	4		M	H		
F-11	11.023	The system shall be able to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	Very important to prescribing for pediatric and geriatric clients.	4		H			
F-11	11.024	The system shall be able to prescribe uncoded medications.	Need to find out what uncoded and coded is? Memo will look into it.	4			H		
F-11	11.028	System shall be able to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications and to customize the printed output of the prescription.	This refers to the "written" output and language on the prescription such as specific language, dispense as written. For instance, users shall be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.	4					
F-11	11.029	The system shall be able to associate a diagnosis with a prescription.		4					
F-11	11.030	The system shall be able to display the associated problem or diagnosis (indication) on the printed prescription.	At least one diagnosis shall be able to be displayed but the ability to display more than one is desirable. Associated problem or diagnosis can be non-structured data or structured data.	4			H		
F-11	11.031	The system shall have the ability to provide links to general prescribing information at the point of prescribing.		4			M	H	
F-11	11.032	The system shall be able to create provider specific medication lists of the most commonly prescribed drugs with a default dose, frequency, and quantity.		4			M	H	
F-11	11.033	The system shall be able to add reminders for necessary follow up tests based on medication prescribed.	Does not imply that this shall be an automated process.	4					
F-11	11.034	The system shall be able to automatically add reminders for necessary follow up tests based on medication prescribed.	As available through 3rd-party drug databases.	4					
F-11	11.035	The system shall trigger alerts of medication prescriptions due to expire and provide ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).		4					

F-11	11.036	The system shall have the ability to electronically record a prescription.		4					
F-11	11.037	The system shall ensure that all electronic transactions involved with medication ordering are compliant with federal, state, and local laws, rules, and regulations.	Example: 1) HIPAA electronic transmission requirements.	4					
F-11	11.038	The system shall ensure that medication history, medication consents, service/treatment plans and recent progress notes can be easily accessed and viewed during the prescription-writing process.		4					
F-11	11.039	The system shall ensure that automated client consent forms are generated to support the prescribing process.		4					
F-11	11.040	The system shall support medication dispensing through an electronic Medication Administration Record that tracks user-defined information for all medications that have been dispensed to clients. The record notes drug allergies, chronic conditions, and other user-defined items.	This component is used primarily at inpatient facilities.	4					
F-11	11.041	The system supports standard interfaces with third party pharmacy management packages for inventory control, ordering and dispensing support.	A third party pharmacy system can either: 1) Integrate with the system's internal medication prescribing, formulary management and medication history components, or 2) Replace them with third party vendor components that are integrated into the systems electronic clinical record and practice management sub-systems.	4					
F-11	11.042	CPOE eRX: The system shall support insurance specific formulary compliance following companies like RXHub		4					
F-11	11.043	CPOE eRX: The system shall provide the ability for the patient to request eRX refills via secured web site.		4					
F-11	11.044	CPOE eRX: The system shall provide the ability to track when a patient does NOT pick up their medication from the pharmacy.		4					
F-11	11.045	CPOE eRX: The system shall provide the ability to track when a patient does NOT pick up their medication from the pharmacy.		4					
F-12	12.001	The system shall be able to order diagnostic tests, including labs and imaging studies.	This includes physicians and authorized non-physicians.	4		M	H		
F-12	12.002	The system shall be able to associate a problem or diagnosis with the order.	May associate more than one problem or diagnosis with the order.	4			H		
F-12	12.003	The system shall be able to capture the identity of the ordering provider for all test orders.		4					

F-12	**12.004**	The system shall be able to capture applicable co-signatures for all test orders.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	**4**			H		
F-12	**12.005**	The system shall be able to capture appropriate order entry detail, including associated diagnosis.	Including associated diagnoses. It is desirable that all information for medical necessity checking be captured.	**4**		M	H		
F-12	**12.006**	The system shall be able to display user created instructions and/or prompts when ordering diagnostic tests or procedures.	Refers to diagnostic test or procedure specific instructions and/or prompts; not client specific instructions and/or prompts. Instructions and/or prompts may be created by the system administrator. A 3rd party product may be used, providing that the instructions and/or prompts appear at the point of care.	**4**		L	H		
F-12	**12.007**	The system shall be able to relay orders for a diagnostic test to the correct destination for completion.	Mechanisms for relaying orders may include providing a view of the order, sending it electronically, or printing a copy of the order or order requisition.	**4**		M	H		
F-12	**12.008**	The system shall have the ability to provide a view of active orders for an individual client.	Additional sorts and filters may be provided.	**4**		M	H		
F-12	**12.009**	The system shall have the ability to provide a view of orders by like or comparable type, e.g., all radiology or all lab orders.	May include filters or sorts.	**4**		M	M	H	
F-12	**12.010**	The system shall be able to electronically transmit a HIPAA compliant secure order to an internal or external laboratory.		**4**					

F-12	12.011	The system shall be able to print out diagnostic test orders.	May be used for manual submission of orders to diagnostic tester or internal review.	4					
F-12	12.012	CPOE Laboratory Data: The system shall check for medical necessity when lab work is ordered.		4					
F-12	12.013	CPOE Laboratory Data: The system shall track all ordered tests and alert the practice if tests are not back within a specific timeline.		4					
F-12	12.014	CPOE Laboratory Data: The system shall provide support so that lab orders are based on best practices and national guidelines.		4					
F-12	12.015	CPOE Orders and Results: The system shall provide an advanced clinical orders capability based on national guidelines and following medical necessity checking.		4					
F-12	12.016	CPOE Orders and Results:The system shall track all orders and indicates when an order result is past due.		4					
F-13	13.001	The system shall be able to define a set of related orders to be subsequently ordered as a group on multiple occasions.	Does not imply that the system needs the ability to create an order set on the fly.	4		M	M	H	
F-13	13.002	The system shall be able to modify order sets.		4		M	M	H	
F-13	13.003	The system shall be able to include in an order set orders for medications, laboratory tests, imaging studies, procedures and referrals.		4		M	H		
F-13	13.004	The system shall be able to display orders placed through an order set either individually or as a group.	Need to be able to see the individual components of the order set, rather than just the name of the order set. Does not mean to break down a lab panel into individual components.	4		M	H		
F-13	13.005	The system shall allow individual items in an order set to be selected or deselected.		4		M	H		
F-14	14.004	The system shall be able to notify the relevant providers (ordering, copy to) that new results have been received electronically.	Examples of notifying the provider include but are not limited to a reference to the new result in a provider "to do" list or inbox.	4			H		
F-14	14.011	The system shall allow user acknowlegment of a result presentation.	This is separate from audit trail.	4		H			
F-14	14.012	The system shall allow secure results to be electronically received for immediate review.		4					
F-14	14.013	The system shall accept results via a bi-directional HI7 interface from all HL7 compliant/capable entities, specifically laboratory, radiology and pharmacy information systems.		4					

F-14	14.020	The system shall be able to accept, store in the client's record, and display clinical results received through an interface with an external source.	Moved from Capture External Clinical Documents: 9.007. In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others.	4		L	H		
F-14	14.021	The system shall be able to receive, store in the client's record, and display discrete lab results received through an electronic interface.	Was Capture External Clinical Documents: 9.002. This may be an external source such as a commercial lab or through an interface with on site lab equipment.	4		H			
F-14	14.022	CPOE Laboratory Data: The system shall automatically post results in patient chart and send a note/message to the provider/nurse based on practice alerts guidelines.		4					
F-14	14.023	CPOE Laboratory Data: The system shall provide the ability to visually compare labs results to prescriptions.		4					
F-14	14.024	CPOE Laboratory Data:The system shall provide the ability to combine results from different labs using the same format.		4					
F-14	14.025	CPOE Laboratory Data:The system shall provide the ability to combine results from different labs using the same format.		4					
F-15	15.008	The system shall be able to prompt user for medication consent as prescription is being written.		4					
F-18	18.001	The system shall check for potential interactions between medications to be prescribed and current medications and trigger an alert to a user at the time of medication ordering if potential interactions exist.	This reduces risk of inappropriate prescribing, prevents pharmacy call backs, and can reduce malpractice liability.	4		M	H		
F-18	18.002	The system shall check for potential interactions between medications to be prescribed and medication allergies and non medication allergies listed in the record and trigger an alert to a user at the time of medication ordering if potential interactions exist.		4		M	H		
F-18	18.003	The system shall be able to prescribe a medication despite alerts for interactions and/or allergies being present.		4		L	L	H	
F-18	18.004	The system shall be able to set the severity level at which drug interaction warnings shall be displayed.		4		L	L	H	
F-18	18.006	The system shall be able to document at least one reason for overriding any drug-drug or drug-allergy interaction warning triggered at the time of medication ordering.	Necessary for medico-legal purposes.	4		M	H		
F-18	18.007	The system shall trigger proactive alerts, for clients on a given medication when they are due for required laboratory or other diagnostic studies, to monitor for therapeutic or adverse effects of the medication.	Limited to availability of databases.	4		L	M	H	

F-18	**18.008**	The system shall , at the time of medication ordering, trigger an alert to a provider that based on the results of a laboratory test, the client may be at increased risk for adverse effects of the medication.	Limited to availability of databases.	**4**					
F-18	**18.009**	The system shall check whether a medication being prescribed has been noted to be ineffective for the client in the past, and trigger an alert to a user at the time of medication ordering if noted ineffectiveness exists.	This criterion assumes that at the time a medication was discontinued, it was marked "ineffective."	**4**		L	M	H	
F-18	**18.010**	The system shall display, on demand, potential interactions on a client's medication list, even if a medication is not being prescribed at the time.		**4**		M	H		
F-18	**18.011**	The system shall trigger drug-disease interaction alerts at the time of medication ordering.	Within the limitations of available databases.	**4**			M	H	
F-18	**18.012**	The system shall trigger drug-disease interaction alerts at the time of entering a problem.		**4**					
F-18	**18.013**	The system shall be able to view the rationale for triggering a drug interaction alert.	Drug reference information typically provided by drug database vendors is an example of the source to obtain the rationale.	**4**			H		
F-18	**18.014**	The system shall trigger alerts based on client age.	This could be based on user defined medication lists or on standard lists such as the Beers lists.	**4**			M	H	
F-18	**18.015**	The system shall interface with third party databases that support automated drug interaction checking to be performed during the prescribing process.		**4**					
F-18	**18.016**	The system shall support accessibility of drug specific education materials from third party databases.		**4**					
F-18	**18.017**	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction and allergy checking will not be performed against the uncoded or free text medication.	Moved from Manange Medication List: 4.019	**4**			H		
F-18	**18.018**	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication.	Moved from Order Medication: 11.025.	**4**			H		
F-18	**18.019**	The system shall be able to update drug interaction databases.	Moved from Order Medication: 11.026. This includes updating or replacing the database with a current version.	**4**					

F-18	18.020	The system shall trigger an alert to a user if the drug interaction information is outdated.	Moved from Order Medication: 11.027. The drug database shall have an "expiration date" based on the frequency of their updates such that when that date has passed, an alert is triggered to the user.	4			L	H	
F-18	18.021	The system shall allow the provider to prioritize/rank the importance of the interactions and/or warnings.	Moved from 4.036.	4					
F-21	21.017	CPOE Orders and Results: The system shall provide Health Maintenance alerts that are automatically provided based on patient conditions and orders that are pre-identified based on national guidelines.		4					
F-24	24.016	The system shall export daily eligibility files and import explanation of benefits (EOB) files to and from pharmacy benefits management companies that contract with the county.		4					
F-24	24.017	The system shall import pharmacy benefits management company EOB files, and appropriately, forward related billing to Medi-Cal and other insurance companies for counties that have assumed risk for pharmacy benefits.		4					
F-25	25.001	The system shall have the ability to provide electronic communication between prescribers and pharmacies or other intended recipients of the medication order.	Until electronic standards are established, FAX is a suitable means of transmission.	4		L	H		
F-25	25.002	The system shall be able to electronically communicate from the prescriber to the pharmacy an initial medication order as well as renewals of an existing order.		4		L	H		
F-25	25.003	The system shall have the ability to electronically communicate cancellations from the prescriber to the pharmacy.		4					
F-25	25.004	The system shall be able to capture and display any renewal requests received electronically from or on behalf of any dispensing entity.	This refers to e-prescribing.	4		L	L	H	
F-25	25.005	The system shall be able to capture and display notification of prior authorizations received electronically from or on behalf of any dispensing entity.	Dependent upon standards development and availability	4					
F-32	32.022	CPOE Laboratory Data:The system shall have the ability to match lab orders to insurance plan requirements and be able to print out an Advance Beneficiary Notice (ABN) if not covered.		4					
F-43	43.067	The system shall be able to interface with a number of key internal and external ordering applications through a standard bi-directional HI7 interface.	Includes medication, laboratory, and diagnostic test ordering.	4					

F-43	43.068	The system shall have the capacity to print orders for manual transmission.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.069	The system shall be able to fax orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.070	The system shall be able to require that all orders be digitally signed at the completion of each order.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.071	The system shall be able to accept orders from multiple locations.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.072	The system shall be able to assign and display an order number for active, hold and pending orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.073	The system shall require that during ordering entry the user acknowledge all error or alert messages prior to being allowed to continue with the data entry function.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.074	The system shall allow the user to accept, override, or cancel and order.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.075	The system shall require the user to enter a justification for overriding, changing, or canceling and order prior to being allowed to continue with the order entry process.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.076	The system shall include a visual indication of orders in need of review.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.077	The system shall detect and display duplicate orders issuing visual and auditory warnings, and allows the user to override the warning after entering a justification for the override.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.078	The system shall include the ability to define order sets for each provider service/treatment department. containing all information specific to one order	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.079	The system shall contain all information specific to one order in one display screen, displaying a list of tests and service/treatments from which to placate one or more orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.080	The system shall display the most commonly used orders to assist in entering orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.081	The system shall display all order sets, including their components by any of the following: Procedure, provider, diagnosis, date.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.082	The system shall be able to specify selected orders and recurring orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.083	The system shall allow providers to inquire on the details of an order.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.084	The system shall be able to access the order inquiry function while in the order entry function.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.085	The system shall display all the detail data associated with the order, including demographics, order parameters, electronic signatures and order status.	Includes medication, laboratory, and diagnostic test ordering.	4					

F-43	**43.086**	The system shall display order summaries on demand to allow the clinician to review/correct all orders prior to transmitting/printing the orders for processing by the receiving entity.	Includes medication, laboratory, and diagnostic test ordering.	**4**					
F-43	**43.090**	CPOE Orders and Results: The system shall route orders and results to the appropriate care giver based on practice-specific guidelines.		**4**					

Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements		
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DRAFT

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-06	6.006	The system shall be able to capture client history in a standard coded form.	Not all data elements may currently be represented in existing standard coding schemes.	5		H	L	M	H
F-24	24.004	The system shall efficiently integrate with community resource databases, client wait lists, call logging, intake screening, pre-registration, registration , remote registration, and client referral systems which gather and/or distribute client demographic and financial information related to an existing or potential client.		5					
F-24	24.005	The system shall support service/treatment authorization opening, approval, deferral, denial, notice issuance, letter generation, tracking and closing for a variety of authorization types (e.g. acute inpatient, residential, outpatient), which constitute discrete episodes of care, compliant with the ASC X12N 278 - Referral Certification and Authorization format.	Includes: 1) County-Issued Internal Authorizations for clients served at county clinics; 2) County-Issued External Authorizations for clients referred to providers in the provider network as part of the county's role as a Medi-Cal mental health plan; 3) Health Plan-Issued External Authorizations to the county from other health plans and managed care companies, which are approving service/treatments to be provided by county staff or contractors.	5					
F-24	24.015	The system shall receive and upload, with proper edit checking, client registration, episode, admission, discharge, authorization, and service/treatment data from contract providers that utilize a different practice management system.		5					

I-01	**1.001**	The system shall receive general laboratory results (includes ability to replace preliminary results with final results and the ability to process a corrected result)	The test files are designed so that products implementing either the HL7 v2.4 or HL7 v2.5.1 standard will be found compliant. The test identifier will be encoded in LOINC, and will be drawn from among 52 common test codes. Refer to *2007 CCHIT Laboratory Interoperability Test Instructions and Applicant Form* for the list of these codes and more information on the interoperability test procedure.	**5**					
I-01	**1.002**	The system shall receive microbiology laboratory results	Organisms will be coded using SNOMED, Sensitivity testing will be coded using LOINC	**5**					
I-01	**1.003**	The system shall espond to a query to share laboratory results	Part of ONC EHR-Lab Use Case Will work with Ambulatory Functionality WG to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.	**5**					
I-01	**1.004**	The system shall send an order for a laboratory test	Further work is need on defining the ordering messages and codes for ordering tests, should include an EHR generated order number for tracking	**5**					
I-01	**1.005**	The system shall send a query to check status of a test order	Part of a function for closing the orders loop as part of quality improvement. Also need to be able to detect orders not matched with results.	**5**					
I-02	**2.001**	The system shall receive imaging reports and view images, includes ECG and other images as well as radiology		**5**					
I-02	**2.002**	The system shall send a query to other providers to share imaging results	see also line IA 5.6 send a query to a registry for documents	**5**					
I-02	**2.003**	The system shall respond to a query to share imaging results with other providers		**5**					
I-03	**3.001**	The system shall send an electronic prescription to pharmacy	Will be aligned with Medicare Part D final regulations	**5**					

I-03	**3.002**	The system shall respond to a request for a refill sent from a pharmacy	Transaction is now wide spread use so that systems that send new prescriptions need to be ready to respond to requests for refills.	**5**					
I-03	**3.003**	The system shall send a cancel prescription message to a pharmacy	Sent by the prescriber to cancel a prescription that was sent previously	**5**					
I-03	**3.004**	The system shall respond to a request for a prescription change from a pharmacy	Sent by the pharmacy to request that the prescriber make changes to a prescription before it is filled.	**5**					
I-03	**3.005**	The system shall send electronic prescription to pharmacy including structured and coded SIG instructions	Standard has been written but has not been finalized, balloted, or implemented. Will work with Ambulatory Functionality WG to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.	**5**					
I-03	**3.006**	The system shall send a query to verify prescription drug insurance eligibility and coverage	An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.	**5**					
I-03	**3.007**	The system shall access and view formulary information from pharmacy or PBM	Usually preceded by a query for insurance eligibility to verify potential source of data.	**5**					
I-03	**3.008**	The system shall send a query for medication history to PBM or pharmacy to access and view medication list from EHR	Part of ONC CE-PHR Use Case, used effectively during Medicare Part D pilots.	**5**					
I-03	**3.009**	The systems shall receive medication fulfillment history	Sent by pharmacy after medication has been dispensed to the client, not currently in wide spread use but is a priority for providers	**5**					
I-04	**4.001**	The system shall register documents with document registry	The ability to register documents in a registry or a repository will be part of the NHIN and final architecture has not been selected.	**5**					
I-04	**4.002**	The system shall send a query a document registry for documents	This criteria is for the query request. This function deals only with the document registry and repository and the references to specific documents have been removed. When the criteria are finalized, any document constraints that are required by the network standards will be identified.	**5**					

I-04	**4.003**	The system shall send documents to repository	This criteria is for sending documents to the repository. The function of sending documents to a repository may be independent of the specific types of documents that will be identified by the network standards. Use of HITSP harmonized standards is expected and it is too early to set those standards at this time.	**5**					
I-04	**4.004**	The system shall respond to a query to provide a document that was previously registered in a repository	This function refers only to the ability to provide a document that has been registered in response to a query. The ability to create documents and medical summaries are discussed in other lines below.	**5**					
I-04	**4.005**	The system shall create and send electronic documentation of a visit such as a consult letter to a referring physicians	Will include narrative data	**5**					
I-04	**4.006**	The system shall Import a clinical document such as a hospital discharge summary, a letter from a consultant, or an imaging report	Will include narrative data	**5**					
I-04	**4.007**	The system shall send Medical Summary to refer or transfer clinical care of client	Used for structured data. Use of CCR will require available translation to CCD.	**5**					
I-04	**4.008**	The system shall receive Medical Summary and import into EHR for consult or transfer of clinical care	May use direct communication or a regional network	**5**					
I-04	**4.009**	The system shall send data to PHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	**5**					
I-04	**4.010**	The system shall receive data from PHR and import into EHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	**5**					
I-05	**5.002**	The system shall import home physiologic monitoring data from clients	Part of AHIC Chronic Care Breakthrough, standards and implementation guides have not been selected yet	**5**					
I-06	**6.001**	The system shall send client specific Public Health Disease Report for a reportable disease	Electronic replacement for traditional reportable disease notifications to health departments, may become part of bio-surveillance in the future.	**5**					
I-06	**6.002**	The system shall send anonymous utilization and laboratory bio-surveillance data to public health agencies	ONC Bio-surveillance Use Case	**5**					

I-06	**6.003**	The system shall have Quality Improvement reporting.	Standards and implementation guides are not available yet and will be evaluated by the Work Group. An AHIC Quality Workgroup is being formed to address this.	**5**					
I-07	**7.001**	The system shall query and receive electronic insurance eligibility information	Separated this requirement from IA-3.6 to avoid duplication of criteria.	**5**					
I-07	**7.002**	The system shall send a query to coordinate client identification	Patient identification coordination will be part of network certification scheduled to begin in 2009 and is required as part of the document transport criteria.	**5**					
I-07	**7.003**	The system shall support standard interfaces to Practice Management and Billing systems.	CCHIT requires more input on stakeholder priorities and feasibility of certifying a standard interface between all EHR systems and all practice management systems and billing systems	**5**					
I-07	**7.004**	The system shall receive client registration data from a practice management system	Transfer of registration and client identification data between practice management systems and EHR is very desirable. Although earlier certification is desirable, without implementation guides, certification cannot happen.	**5**					
I-07	**7.005**	The system shall receive scheduling information from a scheduling system	Transfer of data between a practice management scheduling system and an EHR is highly desirable and is essential for some EHR operations. Although earlier certification is desirable, without implementation guides, certification cannot happen.	**5**					
I-07	**7.006**	The system shall send a query from the EHR to a scheduling system to schedule and appointment	The ability to schedule an appointment during a client encounter will require new standards	**5**					
I-07	**7.007**	The system shall receive electronic authorization for referral from payor	Only a handful of insurers are supporting this today.	**5**					
I-07	**7.008**	The system shall communicate with non-local registry services (that is, to registry services that are external to an EHR) through standardized interfaces.		**5**					
I-07	**7.009**	The system shall provide the ability to use registries or directories to uniquely identify patients for the provision of care.		**5**					
I-07	**7.01**	The system shall provide the ability to use registries or directories to retrieve links to relevant healthcare information regarding a patient that is external to the EHR application.		**5**					
I-07	**7.011**	The system shall provide the ability to use registries or directories to identify payers, health plans, and sponsors for administrative and financial purposes.		**5**					
I-07	**7.012**	The system shall provide the ability to use registries or directories to identify employers for administrative and financial purposes.		**5**					

I-07	**7.013**	The system shall provide the ability to use registries or directories to identify public health agencies for healthcare purposes.		**5**					
I-07	**7.014**	The system shall provide the ability to use registries or directories to identify healthcare resources and devices for resource management purposes.		**5**					
I-07	**7.015**	The system shall provide the ability to use standard terminologies to communicate with other systems (internal and external to the EHR).		**5**					
I-07	**7.016**	The system shall provide the ability to validate clinical terms and coded clinical data against standard terminologies.		**5**					
I-07	**7.017**	The system shall provide the ability to exchange patient data using formal explicit information models and standard terminologies.		**5**					
I-07	**7.018**	The system shall provide the ability to use a formal explicit terminology model.		**5**					
I-07	**7.019**	The system shall provide the ability to use a terminology service (internal or external to the EHR).		**5**					
I-07	**7.020**	The system shall provide the ability to use different versions of terminology standards.		**5**					
I-07	**7.021**	The system shall provide the ability to update terminology standards.		**5**					
I-07	**7.022**	The system shall relate modified concepts in the different versions of a terminology standard to allow preservation of interpretations over time.		**5**					
I-07	**7.023**	The system shall provide the ability to interoperate with systems that use known different versions of a terminology standard.		**5**					
I-07	**7.024**	The system shall provide the ability to deprecate terminologies.		**5**					
I-07	**7.025**	The system shall provide the ability to deprecate individual codes within a terminology.		**5**					
I-07	**7.026**	The system shall provide the ability to cascade terminology changes where coded terminology content is embedded in clinical models (for example, templates and custom formularies).		**5**					
I-07	**7.027**	The system shall apply changes in terminology to all new clinical content (via templates, custom formularies, etc.)		**5**					
I-07	**7.028**	The system shall provide the ability to map terminologies.		**5**					
I-07	**7.029**	The system shall provide the ability to use standard terminology services for the purposes of mapping terminologies.		**5**					
I-07	**7.030**	The system shall provide the ability for a user to validate a mapping.		**5**					
I-07	**7.031**	The system shall provide the ability to use interchange standards[1] as required by realm specific and/or local profiles.	[1]The term “Interchange Standards” refers to the common understanding of the rules governing the physical connectivity, message formats and semantics, used when disparate applications share data. Well understood interchange standards include; HL7 version 2.5, Clinical Document Architecture, X12N, etc.	**5**					
I-07	**7.032**	The system shall provide the ability to seamlessly perform interchange operations with other systems that adhere to recognized interchange standards.		**5**					
I-07	**7.033**	The system shall support terminology standards in accordance with a users’ scope of practice, organizational policy or jurisdictional law.		**5**					

I-07	**7.034**	The system shall provide the ability to exchange data using an explicit and formal information model and standard, coded terminology.		**5**					
I-07	**7.035**	The system shall provide the ability to use different versions of interchange standards.		**5**					
I-07	**7.036**	The system shall provide the ability to change (reconfigure) the way that data is transmitted as an interchange standard evolves over time and in accordance with business needs.		**5**					
I-07	**7.037**	The system shall provide the ability to deprecate an interchange standard.		**5**					
I-07	**7.038**	The system shall provide the ability to interoperate with other systems that use known, different versions of an interoperability standard.		**5**					
I-07	**7.039**	The system shall provide the ability to support standards-based application integration.		**5**					
I-07	**7.040**	The system shall use interchange agreement description standards when exchanging information with partners.		**5**					
F-06	**6.005**	The system shall be able to capture history collected from external sources (other than a personal health record (PHR))	Examples include past service/treatments, diagnoses, procedures, family history and social history and hospitalization. This could include data from online client histories, and information from pharmacy benefit management organizations. This criterion will accept any method of entry for year one, but electronic entry of information will be required thereafter. Separated the PHR into a separate requirement. See 6.014	**6**		M	H		
F-06	**6.014**	The system shall be able to capture history collected from a personal health record (PHR).	Examples include past service/treatments, diagnoses, procedures, family history and social history and hospitalization.	**6**		M	H		
I-03	**3.010**	The system shall access and view a medication history from a PHR	Part of ONC CE-PHR Use Case, may use PHR standards such as HL7/CCD and ASTM CCR instead of NCPDP standards. Will probably use RxNORM medication codes that are more appropriate for consumers and providers than the NDC codes used by pharmacies.	**6**					
I-03	**3.011**	The system shall respond to a query for medication history sent by a PHR	Part of ONC CE-PHR Use Case, may use PHR standards such as HL7/CCD and ASTM CCR instead of NCPDP standards, final standards to be specified by HITSP.	**6**					

I-04	**4.011**	The system shall receive registration summary from client and import into EHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	**6**					
I-05	**5.001**	The system shall secure electronic messaging with clients	Part of AHIC Chronic Care Breakthrough, standards and implementation guides have not been selected yet	**6**					
I-05	**5.006**	PHR: The system shall provide the ability to send information to a client for review via a personal health record (PHR).		**6**					
I-05	**5.007**	PHR: The system shall provide two-way communication with the client via a PHR so that the client can receive messages from the provider and the client can send the practice requests for eRX refills, appointment scheduling, and inquiries.		**6**					
I-05	**5.008**	PHR: The system shall provide the ability for the client to enter in their demographic, insurance information, family history, social history and prior medical history via a secured PHR website.		**6**					
F-03	**moved**	The system shall provide intake forms designed to display current data in the system, such as demographic items. The intake form can be designed to include various types of data including: free text, multiple choice, and drop down menu items.	Was 3.016. Moved to Manage Client Demographics: 2.018						
F-04	**moved**	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction and allergy checking will not be performed against the uncoded or free text medication.	Was 4.019. Moved to Suppor for Drug Interaction: 18.017				H		
F-04	**moved**	The system shall allow the provider to prioritize/rank the importance of the interactions and/or warnings.	Was 4.036. Moved to Support for Drug Interaction 18.021						
F-08	**moved**	The system shall be able to capture the client's immunization history.	Was 8.053. Moved to Mange Client History: 6.013						
F-09	**moved**	The system shall be able to receive, store in the client's record, and display discrete lab results received through an electronic interface.	Was 9.002. Moved to Manage Results 14.021 This may be an external source such as a commercial lab or through an interface with on site lab equipment.			H			
F-09	**moved**	The system shall be able to accept, store in the client's record, and display clinical results received through an interface with an external source.	Was 9.007. Moved to Manage Results: 14.020 In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others.			L	H		
F-09	**moved**	The system shall allow the ability to enter group progress notes .	Was 9.012. Moved to Manage Clinical Notes 8.062						

F-09	**moved**	The system shall not require the user to enter group progress notes for every client. Clinical documentation relevant to all group attendees shall only be entered once. The system shall allow display of a specific client's progress notes.	was 9.013. Moved to Manage Clinical Notes 8.063						
F-11	**moved**	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication.	Was 11.025. Moved to Support for Drug Interaction: 18.018				H		
F-11	**moved**	The system shall be able to update drug interaction databases.	Was 11.026. Moved to Support for Drug Interaction: 18.019 This includes updating or replacing the database with a current version.						
F-11	**moved**	The system shall trigger an alert to a user if the drug interaction information is outdated.	Was 11.027. Moved to Support for Drug Interaction: 18.020 The drug database shall have an "expiration date" based on the frequency of their updates such that when that date has passed, an alert is triggered to the user.				L	H	
F-11	**moved**	The system shall support the collection of data required for the support of various pharmaceutical company indigent patient, “Patient Assistance Programs.”	Was 11.042. Moved to Eligibility Verification 32.016						
F-11	**moved**	The system shall be able to generate drug-specific "Patient Assistance Programs" applications forms to request medications at no cost from manufacturers.	Was 11.043. Moved to Eligibility Verification 32.017						
F-11	**moved**	The system shall support the configuration of multiple "Patient Assistance Programs" application forms that shall be associated with specific medications.	Was 11.044. Moved to Eligibility Verification 32.018						
F-11	**moved**	The system shall track the submission of "Patient Assistance Programs" forms and the status tracking of pending applications.	Was 11.045. Moved to Eligibility Verification 32.019						
F-30	**moved**	The system shall notify users of missing or expired authorizations for service/treatment during the data entry process.	Was 30.008. Moved to Manage Consents and Authorizations: 15.009						
F-30	**moved**	The system shall prevent inappropriate duplicative claiming of service/treatment rendered.	Was 30.017. Moved to Admin A/R 42.198						
F-30	**moved**	The system shall prevent any Medi-Cal claiming for service/treatments rendered while client is located in an Institution for the Mentally Diseased (IMD).	Was 30.018. Moved to Admin A/R 42.199						
F-30	**moved**	The system shall prevent billing Medi-Cal for board & care costs of an Psychiatric Health Facility (PHF).	Was 30.019. Moved to Admin A/R 42.200						

F-30	**moved**	The system shall have user-friendly routines for updating service/treatment charge rates.	Was 30.020. Moved to Admin A/R 42.201						
F-30	**moved**	The system shall allow payor source to be determined by both service/treatment type.	Was 30.024. Moved to Admin A/R 42.202						
F-30	**moved**	The system shall allow payor source to be determined by service/treatment program.	Was 30.025. Moved to Admin A/R 42.203						
F-30	**moved**	The system shall be able to associate a service/treatment with a funding source governed by effective start / end boundaries.	Was 30.026. Moved to Admin A/R 42.204 Examples are: 1) AB3632 IEP service/treatments; 2) Grant funding timeline restrictions; 3) Insurance company or another county authorization period boundary dates;						
F-43	**moved**	The system shall be able to flag, prevent or suspend service/treatment entry outside scope of practice. (i.e. CBT..)	Was 43.036 . Moved to Service/Treatment Management 30.027 Review again						
F-43	**moved**	The system shall simultaneously trigger alerts to users of each other's presence in the same record, where such access is permitted.	Was 43.044. Moved to Concurrent Use: 39.005						
S-01	**moved**	The system shall be able to detect security-relevant events that it mediates and generate audit records for them. At a minimum the events shall include: start/stop, user login/logout, session timeout, account lockout, cleint record created/viewed/updated/deleted, scheduling, query, order, node-authentication failure, signature created/validated, PHI export (e.g. print), PHI import, and security administration events. Note: The system is only responsible for auditing security events that it mediates. A mediated event is an event that the system has some active role in allowing or causing to happen or has opportunity to detect. The system is not expected to create audit logs entries for security events that it does not mediate.	Was 1.005. Moved to Security Audit: 5.015.				X		
S-01	**moved**	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and cleint identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.	Was 1.006 Moved to Security Audit: 5.016.			X			X

S-01	**moved**	The system shall provide authorized administrators with the capability to read all audit information from the audit records in one of the following two ways: 1) The system shall provide the audit records in a manner suitable for the user to interpret the information. The system shall provide the capability to generate reports based on ranges of system date and time that audit records were collected. 2) The system shall be able to export logs into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).	Was 1.007 Moved to Security Audit: 5.017.			X			X
S-01	**moved**	The system shall be able to support time synchronization using NTP/SNTP, and use this synchronized time in all security records of time.	Was 1.008 Moved to Security Technical Services: 4.016.			X			X
S-01	**moved**	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T08:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.	Was 1.009 Moved to Security Technical Services: 4.017.				X		
S-01	**moved**	The system shall prohibit all users read access to the audit records, except those users that have been granted explicit read-access. The system shall protect the stored audit records from unauthorized deletion. The system shall prevent modifications to the audit records.	Was 1.010 Moved to Security Audit: 5.018.			X			X
S-01	**moved**	The system shall allow an authorized administrator to enable or disable auditing for groups of related events to properly collect evidence of compliance with implementation-specific policies. Note: In response to a HIPAA-mandated risk analysis and management, there will be a variety of implementation-specific organizational policies and operational limits.	Was 1.012 Moved to Security Audit: 5.019.				X		
S-04	**moved**	When passwords are used, the system shall not transport passwords in plain text.	Was 4.002. Moved to Security Authentication 2.017			X			X
S-04	**moved**	When passwords are used, the system shall not display passwords while being entered.	Was 4.003. Moved to Security Authentication 2.018			X			X